

Changing Lives



*Ohio's
Action
Agenda
for Mental
Health*



Report of Ohio's Mental Health Commission
January 2001

Ohio's **Mental Health** **Commission**



Left to right: Les Bostic, Tom Perrone, Tracey Bennett, Debbie Nixon-Hughes, Eric Ladd, Jerald Kay, Mark Munetz, Les Abel, Bernie Schell, Sue Buchwalter, Terry Dalton, Jeanne Clement, Don Anderson, Cindy Holodnak, Karen Scherra. *Not shown in photo:* Ella Thomas, Elise Sanford, Ed Comer.

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Message from the Chair

January, 2001



Jerald Kay, M.D.

Dear Director Hogan:

The United States Congress declared the 1990s the Decade of the Brain. This period, and the preceding 40 years, was marked by extraordinary growth in our understanding of the diagnosis and treatment of mental illness. Advances in neuroscience, psychopharmacology, behavioral science, genetics, molecular biology, and epidemiology have revolutionized our ability to treat those with mental disorders to the point that our interventions are remarkably effective and surpass that of the treatment of many medical disorders. Unfortunately, of the one of every five adults and children who live in Ohio and who suffer from a mental illness, a startling number receive little or no treatment. Stigma about mental illness remains pervasive in our society and the availability and access to mental health services has become increasingly problematic.

Paralleling these great scientific advances, there have been dramatic changes in the structure, role, and responsibility of Ohio's public mental health system. Recognizing these and other challenges and opportunities, you gave the Commission on Mental Health Services a clear charge: to help the Department establish a new strategic direction and assist in the identification of new ways to ensure that Ohioans can receive the mental health treatment and services they need and deserve.

The Commission's response to your charge is contained in the pages of this report. It reflects what we have learned from public forums, meetings and discussions with consumers and their families, service providers, mental health boards, public officials, and independent experts in many areas of the mental health field. Our recommendations are the result of a yearlong intensive study and in depth deliberation.

Our response to the questions you asked us to address is clear — a stronger and more effective mental health system for Ohio must focus on four fundamental areas. These include: 1) improving timely access to appropriate mental health services; 2) providing effective treatment that promotes positive outcomes and recovery/resiliency from mental illness; 3) improving the design, function and integration of Ohio's public mental health system and promoting the collaboration between the mental health system and other entities that promote health, vocational, education, justice, and housing services (to name but a few); and 4) increasing funding for mental health services and improving the alignment of resources to support effective treatment and recovery/resiliency.

The Commission's report is a comprehensive plan of action to meet the needs of those Ohioans with mental illness, and it provides a strategy for prevention and early intervention. Yet, we do not consider the submission of this report as the final word on this critical subject. Rather, it must be the beginning of a new effort by families and consumers, mental health boards and agencies, advocacy and other professional organizations, government, and other interested parties to increase the quality of mental health services and improve treatment outcomes and promote recovery and resiliency.

We submit this report with respect for the complexity of these challenges and with a determination to join in building a system of services that improves our capacity to change lives and to promote mental health throughout Ohio.

Sincerely,

Jerald Kay, M.D.
Professor and Chair
Department Psychiatry
Wright State University

Charge to the Commission

**Michael F. Hogan, Ph.D., Director
Ohio Department of Mental Health
November 15, 1999**

The Mental Health Commission is a diverse group of interested parties who have been appointed to consider and recommend changes in the Vision, Mission, Values, and Priorities for mental health in Ohio and to make recommendations for a new strategic management plan for the Ohio Department of Mental Health. The Commission will serve for a time-limited period of approximately one year.

The work of the Commission is timely, considering current achievements, opportunities, and challenges. Nationally, 1999 will be remembered as the year of both the first White House Conference on Mental Health, and the first ever Surgeon General's Report on Mental Health. There is a strong scientific base for improvements in mental health, and growing public awareness of the need for mental health care.

In Ohio, a decade of successful reform ushered in by the Mental Health Act of 1988 (S.B. 156) has just been completed. As intended, reform produced a "devolved" system managed at the community level and oriented strongly to community care. However, this successful reorganization of mental health care has not produced uniformly good outcomes for consumers. Therefore, one pressing question for the Commission is how to improve and assess the quality of care. Strategies for performance improvement, how to define and use "Best Practices," and use of research results should be considered.

A related challenge involves the dilemma of reducing ineffective or costly regulations while improving accountability to consumers and funders. Many ODMH regulations—both clinical and financial—are more than a decade old. They may drive up costs without improving quality beyond required "minimums." ODMH is now developing approaches to reduce regulations while increasing accountability, and the Commission should review this strategy.

New fiscal challenges have emerged for mental health. Following a decade of dramatic reductions in state hospital budgets, hospital downsizing and consolidation has run its course as a source of new community funding. With levels of hospital use about 60% below national norms, further reductions are unlikely. Increased Medicaid revenues require excessive state and local matching funds in some communities. The ODMH budget and local levies have increased less than inflation in recent years, while demand for services increases and costs escalate. The Commission will advise ODMH on resource needs and strategies.

Independent guidance from the Commission will also direct new thinking about priorities for mental health in Ohio. In a time when resources are limited, needs are increasing, and quality must be improved, some tough decisions must be made. Ohio's public mental health system has placed a priority on serving more needy adults and children while preserving access for basic care. But there is some evidence that these policies have merely increased enrollment, not the appropriateness of care. Services have helped consumers avoid hospitalization, but not necessarily to meet their personal goals. New priorities should also consider evidence about the effectiveness of early intervention.

Commission Members

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Ella Thomas, CEO,
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A Word about Language and Terms in this Report

The Commission rigorously debated the terms and labels that are used in this report. Language and terms are very important, and improper use of language can contribute to stigma. For purposes of this report, the Commission chose to use “mental health” and “mental illness,” generally, to describe the disorders that affect people in the care of the public mental health system. These terms, and their definitions, come from *Mental Health: A Report of the Surgeon General*. However, the Commission strongly believes that more work must be done to re-examine and perhaps refine the common language that is used in the public mental health system to define these illnesses and the people who suffer with them. A recommendation is included in Chapter II. This document also contains a glossary with definitions for many of the specific terms that are used herein.



Mental Health



Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. From early childhood until death, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem.



Mental illness refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.



— *Mental Health: A Report of the Surgeon General*



Mental Illness

Overview

I

One in five Americans experiences some form of a mental illness every year. Untreated, mental illness is extremely disabling and costly to society and to families. In the United States, mental disorders collectively account for more than 15 percent of the overall burden of disease from all causes, which is slightly less than the burden associated with all cardiovascular conditions and slightly more than the burden associated with all forms of cancer (*Mental Health: A Report of the Surgeon General*). In Ohio, mental illnesses and emotional and behavioral disorders are major barriers to school success, employment, housing and quality of life, and a leading contributing factor to poverty.

One in five Americans experiences some form of a mental illness every year.

Mental illness is expensive. Direct treatment costs (public and private) were estimated at \$69 billion nationally in 1996, translating into over \$2.5 billion in treatment costs in Ohio. But the costs of **not** treating mental illness are even greater. So called “indirect” costs (such as disability, time lost from work, etc.) were estimated nationally at \$79 billion in 1996. Estimated indirect costs of mental illness in Ohio were over \$3 billion. Thus, mental illness costs Ohio over \$5 billion annually, with most of the impact being disability costs, lost productivity and excess costs of other problems (absenteeism, homelessness, suicide and increased medical care) resulting from untreated mental illness (Surgeon General’s Report).



On the positive side, thanks to advances in bio-science, treatments and interventions for people with a mental illness are becoming more specialized and effective—on par with, and often more successful than, medical interventions for “physical” ailments. The Surgeon General’s Report indicates that the efficacy of mental health treatments is well documented, and a range of treatments exists for most mental disorders. Much of this progress can be traced to increased knowledge of the brain and the development of new and improved psychotropic medications and research-based psychotherapies and psychosocial treatments.

Despite these advances, nearly half of all people with a severe mental illness do not receive treatment (Surgeon General’s Report). There are many reasons for this, including lack of or inadequate insurance coverage, stigma associated with mental illness, financial disincentives to treatment and lack of qualified professionals to provide treatment. Furthermore, in Ohio and across the country, too many people who **do** seek treatment do not receive services of appropriate quality or quantity.

A Decade of **Progress** Leads to New **Challenges** for Ohio's Public Mental Health System

In the 1990s, the public mental health system in Ohio was hard at work implementing the Mental Health Act of 1988 (Am. Sub. S.B. 156). This landmark legislation had two primary goals: (1) to move toward **community treatment** rather than institutionalization, and (2) to emphasize **local direction** rather than state control of the system. Twelve years later, the structural reform is complete and the primary goals of the legislation have been met.

Fiscal and service responsibility is unified at the local board level, and in many cases, small counties have combined their responsibilities, resulting in 50 community mental health (CMH) and alcohol, drug addiction and mental health services (ADAMHS) boards covering Ohio's 88 counties. These boards are responsible for Medicaid matching funds, in charge of resources formerly allocated by the state to state-run institutions, and required to assure that a full range of community support services is available. The boards themselves do not provide direct treatment services, but contract with providers to do so.

Changes have also led to service efficiencies within ODMH. Since 1988, five ODMH hospitals (including three children's hospitals) were converted to other uses and owners; three hospitals were consolidated into other hospitals; and two hospitals were closed. At the same time the ODMH Community Support Network grew from six programs to over 90. As a result of these reforms, Ohio is now recognized as having one of the strongest community mental health systems of any large state, one that mirrors the state's general political preference for local rule with state support.

The successes of the past decade are tempered by the reality of emerging crises in communities across Ohio. The growth in local funding for mental health during the 1990s—due to local levy success, an influx of Medicaid funds, and savings from the consolidation of state hospitals—has leveled off, while demand for services continues to expand. The reduction in the size of the state hospital system is complete, meaning that further resources cannot be expected to meet emerging needs. Local and state funding is not keeping up with inflation, and the obligation to produce Medicaid matching funds is fast becoming a drain on local system resources. These and other factors (such as the supply of professionals, low pay and turnover in the workforce) now threaten local systems' ability to meet community demands.

Ohio's Mental Health: Building Our Future Together

In November 1999, ODMH Director Michael F. Hogan, Ph.D., appointed a time-limited **Commission on Mental Health Services** to review and update the vision, mission, values and priorities for mental health in Ohio, and to develop a strategy for meeting these objectives. The Commission was also asked to coordinate the mental health system's work on Governor Taft's Ohio Access Initiative, which is charged with improving community care options for Ohioans with a disability. The Commission is the second step in the Department's Building our Future Together Initiative, which began with a series of nine public forums throughout the state in the fall of 1999. The Commission reviewed the feedback and discussions from the forums and consulted with independent experts from across the country to develop this document—**Changing Lives, Ohio's Action Agenda for Mental Health**—which charts strategic direction to meet consumer and organizational objectives that are inherent in the mission, vision and values.

The development of this report has been designed to maximize public input. The forums were widely publicized, and more than one thousand people from throughout the state participated and shared their ideas on how to improve the quality of the public mental health system. The forums solicited input from the public regarding mission, vision, values, communication and priorities, as well as input on a series of critical issues in mental health today, including best clinical and administrative practices, children and adolescents, children and families, community support services, criminal justice, cultural competence, mental health and schools, and housing and employment.

A summary of the forum dates, locations, discussion topics and feedback is on the ODMH Web site at www.mh.state.oh.us.

Based on discussions and feedback, the Commission composed new statements of mission, vision, and values for mental health in Ohio. The Commission also developed a multi-faceted strategy for meeting these objectives. The strategy focuses on **four main “areas of attention” that are keys to achieving the vision, mission and values:**

Access

Quality and effective services

System design, function and integration

Funding support

All of the Commission's recommendations to support and implement the new vision, mission and values flow from these four areas of attention. Recommendations also focus on issues specific to children and youth, adults and older adults. The new vision, mission and values, as well as all of the recommendations, also address several common sense standards, or “filters,” to assure appropriateness and effectiveness. The areas of attention and filters are based, with some modification, on the Surgeon General's Report. Together, they make up the matrix for this report.

OHIO'S MENTAL HEALTH

VISION

Ohio will be a community of mentally healthy people who lead fulfilling and productive lives. It will be a caring community with strong compassion for, and a determination to respond effectively and respectfully to, the needs of all citizens with mental illness and behavioral disorders.

MISSION

The mission of Ohio's mental health system is to establish mental health as a cornerstone of health in Ohio, and ensure that quality mental health care is available to all Ohioans at all stages of life.

VALUES

Ohio's mental health system is committed to these values:

Respect

We treat all people with respect and dignity. We support individual choice and build on the strengths of individuals, families and communities.

Integrity

We are honest and ethical in all our dealings. We keep our promises and are accountable for our actions.

Dedication

We are committed to helping every Ohioan with mental health needs. Our goal is to exceed the expectations of those we serve.

Quality

We strive to provide the highest quality services to the people of Ohio. We embrace and respect individual differences and provide culturally competent services and interventions in a manner that is acceptable to consumers and families and that helps them to achieve desired outcomes.

Teamwork

We promote partnerships that reach across system and organizational boundaries.

STRATEGY FOR ACHIEVING MISSION, VISION AND VALUES

Get there by . . . Improving access to
Effective treatment and recovery through evidence-based best practices, by
Improving design, integration and function of the service delivery system
and related components at the local, state and federal level, and
Increasing funding and aligning fiscal resources to support improved
access to effective treatment and recovery based best practices

Access to Care

Timely access to appropriate services is a key to meeting the needs of consumers and families. For a variety of reasons, the demand for services is now outpacing the mental health system's ability to provide access to services. Service needs are also changing and becoming more diverse and broad.

Quality and Effective Services

Services that are provided through the mental health system must meet the highest standards of quality and promote positive outcomes and recovery. Services must be individually tailored to meet the self-identified needs of each recipient.

System Design, Function and Integration

Local, state and federal mental health authorities and programs must work more efficiently together to promote access and effective treatment. The mental health system must also work more effectively with other public and private systems and entities that play a role in promoting mental health.

Funding Support

Efficiency of operations is a key to improving access to effective treatments. But increased funding and enhanced coordination of funding systems (i.e. federal funding programs supporting local service priorities) is also a must.

Filters – The Recommendations Must:

- Be acceptable to families, consumers, mental health professionals, organizations and the general public, so that all groups can support the recommendations and participate in their implementation.
- Promote increased quality, improved outcomes and increased satisfaction for all customers. They should also promote increased accountability and the reduction of unnecessary regulations.
- Be person-centered. The main impetus of each recommendation should be to improve the quality of life of people with mental illness and their families.
- Promote an effective use of resources.
- Focus on promoting mental health as well as treating mental illness.
- Promote recovery and resiliency.
- Promote and embrace cultural competence. Cultural competence is a set of congruent behaviors, attitudes and policies that integrate within a system, agency or among professionals, and enable that system, agency or professional to work effectively with all people and provide services that are tailored to meet the self-identified needs of each individual.
- Help promote the transition of consumers and families between especially challenging life stages (i.e. childhood to adolescence, adolescence to adulthood, adulthood to old age).



Appropriate Access is the assurance that consumers are aware of the local array of mental health services and are afforded the opportunity to receive needed services and supports in a timely manner. Accessibility requires that community mental health services be conveniently available, culturally appropriate, financially affordable, and of sufficient quality and quantity to respond to new referrals within appropriate time frames, based on acuity. Recommended time frames for initial intervention are: urgent/crisis services within three hours, emergent services within three days and basic services within 14 days.

— Commission on Mental Health Services

Demand Expectations

For a variety of reasons, demand and expectations for mental health services at the community level are increasing:

■ ***Nationally, the level of mental health care funded by insurance plans is decreasing, shifting the burden to the public sector.*** From 1986 to 1996, according to a MEDSTAT study, the public share of behavioral health expenditures grew from 49 percent to 54 percent. Ohio is one of less than 20 states that have not passed a “parity” law requiring private insurance to cover mental illness at the same rate as other illnesses, therefore, demand for comprehensive services is greater here than in many states.

■ ***The role of mental health in the development of healthy and successful children and adults is being recognized by policy makers at the local, state and federal levels.*** For example, welfare reform has focused attention on the prevalence of depression and other illnesses among the hardest-to-employ population. More and more children in the child welfare system and the juvenile justice system are requiring higher levels of mental health care. Increasing concerns about violence and disruption in schools have encouraged the need for close collaboration between the education and mental health systems. The result is a significant increase in demand for services for individuals who fall outside the mental health system’s current priority populations of children with serious emotional disturbances and adults who are severely mentally disabled. Although the Mental Health Act of 1988 stated that the primary responsibility of community mental health systems is to provide care for citizens with the greatest level of mental impairment, ***the responsibility for providing care has increased in the past decade to include many other populations, including the following:***

- Children and families involved with Public Children Services Agencies
- Families currently receiving cash assistance and those struggling to remain off of cash assistance (Ohio Works First)
- Adolescents in the juvenile justice system
- Children with multiple needs involved with Family and Children First Councils
- Schoolchildren exhibiting behavior problems in severe behaviorally handicapped classes and alternative schools
- Children with mental retardation and developmental disabilities who do not meet the Children’s Ohio Eligibility Determination Instrument (COEDI) disability requirement for services through Ohio’s Mental Retardation and Developmental Disability system
- Non-violent offenders who have been determined to be not guilty by reason of insanity or incompetent to stand trial and are released from ODMH forensic centers to community treatment
- Offenders held or serving their sentences in county jails

- ***Ongoing reductions in private inpatient capacity, highlighted by the closing of private psychiatric beds in general hospitals, have increased pressure on the public system.***
- ***An increased public focus on urging people with mental illness and emotional disorders to seek help*** (highlighted recently by the White House Conference on Mental Health and the Surgeon General's Report), as well as publicity about the increased effectiveness of newer interventions and medications, has encouraged more people to seek services.
- Mental health services to inmates in Ohio's prisons have improved dramatically in the last decade as a result of the Department of Rehabilitation and Correction's implementation of a consent decree following *Dunn v. Voinovich*. As a result, ***more than 1,400 mentally ill inmates per year are now completing their sentences with referrals to community care.***
- ***In 1989, most community mental health boards took on the responsibility for managing treatment services for addiction to alcohol and other drugs.*** Today, 43 of the 50 local boards are combined mental health and alcohol and drug addiction services boards. Public funding for substance abuse treatment has been historically inadequate, so the mental health system has been disproportionately responsible for making up the gap in services for people with co-occurring mental illness and substance abuse problems.

The demand for mental health services is increasing and is expected to continue to rise. For most of the past decade, Ohio's response to unmet need could be addressed through the reallocation of resources from state hospitals, increased billings to Medicaid, and increased local levies. Each of these funding sources, however, has dried up, as explained below:

- ***Resources from state hospitals.*** As part of the implementation of the Mental Health Act, ODMH worked closely with local communities to reduce the size of the state hospital system so that the funds otherwise used to run these facilities could be used to provide more appropriate and cost-effective services in the community. Since 1988, five ODMH hospitals (including three children's hospitals) were converted to other uses and owners; three hospitals were consolidated into other hospitals; and two hospitals were closed. At the same time, the ODMH Community Support Network grew from 6 programs to over 90.

The downsizing of state hospitals now appears complete and the influx of money from state hospital consolidations has reached its pinnacle. State hospital utilization levels in Ohio are now substantially below national norms. Significantly, for every other category of institutional care (prisons, intermediate care facilities for the mentally retarded, youth services facilities, and nursing homes), per capita use rates in Ohio are ***above*** national norms, while in mental health, institutional usage is very low. Some other states have addressed this by maintaining high levels of Medicaid-supported psychiatric hospital care. But Medicaid-paid hospitalization rates in Ohio have actually ***declined*** in recent years and are ***below*** national norms.

- ***Medicaid billings.*** Billing Medicaid for community mental health services has allowed for expanded capacity. However, on a statewide basis, Medicaid's significant funding role is

increasingly problematic. ***In some communities, declining Medicaid eligibility related to welfare reform has reduced Medicaid revenues to mental health agencies.*** So while the agencies don't have the revenue, they still must provide the services.

In some communities, Medicaid matching funds requirements are becoming a significant drain on local budgets. Medicaid only covers about one of three categories of mental health care, and only about one in three community mental health clients is Medicaid eligible. Despite this, Medicaid match requirements are consuming more than 35 percent of available revenues in a number of local mental health systems. Furthermore, the fact that every unit of Medicaid services must be separately documented and billed has resulted in a counter-productive cycle where physicians, therapists and case managers work on billing paperwork instead of treating people. The indefinite delay of Ohio's work toward a cost control/flexibility waiver compounds these problems and increases fiscal pressure on local services.

- ***Local levies.*** During the late 1980s and early 1990s, there were significant increases in local levy support of mental health. These resources were critical in meeting the mandates shifted to local communities by the Mental Health Act. In 1999, dedicated mental health levies totaled \$140 million statewide, and an additional \$26 million was allocated to mental health from the human services levies in Cuyahoga and Montgomery counties. However, ***in the past six years, total levy resources available to local boards have increased at a rate less than inflation. No new levies have been passed since 1994. Added to this is further reduction of the local tax base through utility deregulation and tangible property tax changes*** enacted in 1999 by the Ohio General Assembly.

As a result of these financing trends and continued increases in demand and operating costs, a number of local mental health boards are now in unsustainable deficit spending patterns. A number of others have reduced or eliminated existing services to bring expenses in line with revenues, increasing waiting lists and gaps in care. In a few communities local mental health agencies have closed down because of a combination of funding limits, human resource crises related to staff turnover, and management problems. Unless we stabilize the safety net system, these problems will accelerate statewide.

The strain of these factors on local systems is having a dramatic effect on consumers' access to services. A recent survey by the Ohio Council of Behavioral Healthcare Providers revealed these disturbing realities:

- The waiting list for one organization had increased to 98 days. Almost every respondent to the survey reported that waiting lists are growing.
- Access to care is getting worse—with average waits for psychotherapy and psychiatric evaluation rising to 28 and 60 days, respectively.
- Increasing caseload sizes are stretching staff capabilities and affecting quality of care. One provider reported that its caseload ratio of severely mentally disabled (SMD) clients to treatment staff has reached 80:1.

Overall Finding on Access: *The public mental health safety net is stretched too thin and has holes in some places. Statewide, the supply of mental health services does not meet current demand and will not meet increasing demand in the future.*

Access Gaps, Issues and Recommendations

The Commission acknowledges several crosscutting issues—public attitudes and awareness, staffing needs, and gaps in insurance coverage—that have a serious impact on the ability of all people with a mental illness to access quality services that promote recovery. These issues (described in detail below) require the attention of leaders and policy makers at the state and local level. Additional access-related issues will also be addressed in the chapters to follow on funding support, effective treatment and system design, function and integration.

1. Public Attitudes and Awareness

Increasing public awareness about mental health and treatments for mental illness is critical, and not without its challenges. Making the public more aware that mental illnesses are often very manageable with the proper medications and interventions, and providing information about how and where to access these services, will undoubtedly increase the pressure on the already strained public mental health system. Since two-thirds of people with all diagnosable mental disorders, (including those with serious mental illness) do not seek treatment, lack of information and stigma associated with mental illness are major barriers to people receiving the services they need.

The Surgeon General's Report suggests that more Americans now believe that mental illness is a disease of the brain, they understand its impact on society, and they are willing to accept that it is a public health problem. But more still must be done to educate the public, as the stigma associated with mental illness is still a persistent problem that discourages people from seeking services. Public education must focus on awareness and knowledge while simultaneously improving attitudes and reducing stigma. Success stories about positive outcomes for consumers are also a valuable tool to fight stigma.

One serious public awareness issue that is gaining momentum in Ohio and across the nation is suicide. Suicide is the second most common cause of death in the United States for young people ages 15-24. Suicide takes the lives of more than 31,000 Americans and 1,100 Ohioans each year—40 percent more than homicide—and affects the lives of countless others (Surgeon General's Report). Yet suicide is preventable. The Surgeon General has gathered leaders from all of the states to help

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develop a national strategy to prevent suicide. Ohio has been active in developing programs and strategies to prevent suicide. But more can and must be done. Ohioans must know where to turn for help for themselves or their loved ones who show signs and symptoms of depression and suicide.

1

Access Finding: *Mental illness is a serious public health problem, not unlike cancer or heart disease, that affects one in five Ohioans. People with a mental illness should seek help from a mental health professional.*



Recommendations

- A.** The mental health system should increase its commitment to raising awareness about mental illness and the availability of appropriate services. It must support existing programs and promote new and innovative opportunities to reduce stigma associated with mental illness.
- B.** Ohio should build an initiative to reduce suicides and support the Surgeon General's Call to Action to Prevent Suicide and the upcoming National Suicide Prevention Strategy.
- C.** ODMH should convene a workgroup to examine and suggest modifications to the common language (for example, "SED and SMD") that is used by the mental health system to describe these illnesses and individuals suffering with these illnesses. Language used by the system should not promote stigma.

2. Staffing Needs

A major reason that local mental health systems are not able to meet the needs of their communities is a shortage of adequately trained clinical staff. This is in many ways a fiscal problem, because local public mental health systems do not have enough resources to hire and retain the amount of staff they need to meet access demands. An overall shortage of mental health professionals also contributes to the problem. The need is especially great for child psychiatrists and other clinicians who specialize in serving children, and in rural areas such as Appalachia.

Respondents to the 2000 Salary and Benefits Report, a survey of the membership of the Ohio Council of Behavioral Healthcare Providers, reported that average staff turnover for the most recent year was 22 percent. Five years ago, staff turnover was 12 percent.

The study also suggests that:

- Recruiting new licensed professionals is increasingly difficult because public agencies cannot afford market salaries. Agencies cannot compete with private-sector or government on salaries. Several providers report that starting salaries are \$4,000 to \$8,000 below the market rate.
- Rural areas are facing serious staff recruitment and retention problems, particularly for independently licensed professionals.

According to a member survey recently compiled by Mental Health Corporations of America:

- The average mental health center psychiatrist manages a caseload of 375 adults. In Ohio, the number is 811.
- The average staff of full-time employees (FTEs) in the national sample includes 36 percent graduate-prepared persons. Among centers reporting from Ohio, only 25 percent of the FTE staff were graduate-prepared.
- Nationwide, the number of severely ill adults served per graduate-prepared FTE was 39. In Ohio the number of adults per graduate-prepared FTE was 73.

Ohio's public mental health system must do a better job recruiting, training and retaining quality clinical staff. Despite the development of better medications, the one-on-one interaction between clinical staff, caseworkers and consumers is still the cornerstone of all mental health interventions. Staff who lack sufficient training or experience, especially in providing research validated clinical services, compromise the quality of service provided to consumers. Insufficient numbers of staff hinder access. Frequent staff turnover and unfilled positions threaten the continuity of care that is provided to consumers, and often leads to waiting lists for services.

2

Access Finding: *Ohio's public mental health system has a shortage of well-trained clinicians. The system has difficulty recruiting new professionals and retaining the quality staff it already employs.*



Recommendations:

A. ODMH should take the lead and work with local systems partners and colleges and universities to increase the number of qualified clinical professionals in the public mental health system. Specific attention should be paid to the following:

- Improving training and recruitment at the university level, including tailoring university training and residency programs to fill specific needs of the public mental health system.
- Providing adequate salaries to recruit and retain quality mental health staff.

Recommendations, continued:

- Considering incentives to trainees of various disciplines who commit some defined period of service in the public mental health system, particularly in areas of the state with the greatest staffing needs.
- Retaining staff by improving working conditions and increasing job-related development opportunities.
- Improving staff productivity by reducing paperwork.
- Training staff at the university and residency levels to be proficient in delivering services that are identified as evidence-based best practices.



3. Parity in Insurance Coverage

Mental health services to adults are generally provided in two tiers: (1) private insurance plans and (2) the public mental health system. Employment-based private insurance coverage is usually broad but shallow. Most health insurance covers some treatment for mental illness, but an estimated 95 percent of policies will not adequately cover the costs of treating serious mental illness such as schizophrenia, bipolar disorder, or some forms of depression, to name a few. People with serious conditions rely on the public mental health system as a safety net, especially considering that a severe and persistent mental illness often leads to a loss of employment and associated benefits. Nationally, private expenditures are declining as a percentage of total mental health costs.

Thirty one states and the Congress have enacted parity laws in an attempt to bring private insurance coverage for mental illness on par with coverage for other illnesses. A “parity” bill was introduced but did not pass in the Ohio General Assembly in the last two sessions. Actuarial studies indicate that the cost of parity, when combined with managed care and medical offsets, is very small.

3

Access Finding: *Most private insurance policies have artificial limits that prohibit adequate coverage of serious and persistent mental illness. Parity for mental health services in private insurance plans is offset by the cost savings and benefits to individuals, families and society.*

Recommendation:

A. Ohio should pass a strong and comprehensive parity law for mental health coverage that extends those benefits now provided for state employees and their dependents to all people in state-regulated insurance plans.

Access Issues Impacting Children and Youth

Exciting research in neurobiology tells us that the experiences that fill a baby's first days, months, and years have a tremendous impact on the architecture of the brain and on the nature and extent of their adult capacities. Other research confirms that quality early childhood programs for young children can significantly reduce the likelihood of later problems such as grade retention, school dropout, delinquency, and violence. New research indicates an alarming increase in the use of psychotropic medications for children under the age of five. Growing numbers of early childhood providers report increasing numbers of children with severe behavior problems. (JAMA, Vol. 283 No.8, Feb. 23, 2000)

Ohio is home to more than 2.84 million children and youth. Of these, about 175,000 were under age five and living in poverty in 1996. Research suggests that as much as 20 percent of these young children are at high risk for being unable to relate to others, poor academic performance, developmental delays, and post traumatic stress disorders. They are also usually more sad, anxious, aggressive, and impulsive than their peers. In addition, they are at a higher risk to use alcohol, drugs and tobacco, and to engage in other risky behaviors as they get older.

About 1.8 million children and youth are enrolled in Ohio's public schools. Of the 432,000 students in 21 urban school districts, the graduation rate is 43 percent. More and more students statewide are being suspended and expelled for disruptive behaviors in the classrooms. There is a significant increase in alcohol use among children under age 13 (30 percent in 1993, 37 percent in 1997, and 45 percent in 1999). Drug use, teen sexual activity, and low passage rates on school proficiency tests also contribute to a dismal picture for many of Ohio's children and youth. About 23 percent of all high school students report having considered suicide.

The Surgeon General's Report suggests that as many as 378,000 Ohio students (21 percent) may suffer from a diagnosable mental or addictive disorder, and 198,000 (11 percent) may have a mental health disorder that significantly impairs their daily functioning. Other studies indicate that only about one percent of children and adolescents with a serious emotional disturbance are in special education courses. Of the 21 percent of children and adolescents with a diagnosable mental health problem, less than half receive any type of treatment and less than a quarter receive specialty mental health care. In Ohio, in fiscal year 1997, approximately 47,600 children (about 1.5 percent of all children in Ohio) received community mental health services. Of those, 22,975 (48.2%) were severely emotionally disturbed.

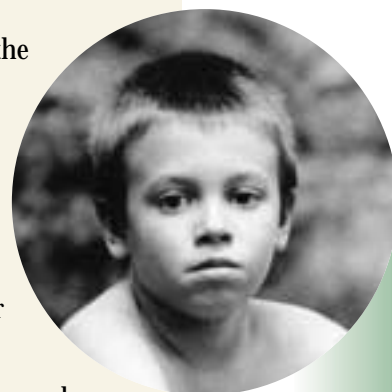
Students with a serious emotional disturbance are characterized by a broad range of behaviors that impact their ability to learn and develop satisfactory interpersonal relationships with peers and teachers. These children and adolescents often have short attention spans and suffer from conduct disorders, depression, aggression, withdrawal, and persistent fear. Recent research by Case Western Reserve University confirms national data that indicates that children with mental health problems are more likely to be victims of, witnesses of, and initiators of

more acts of violence than children without such illnesses. As a result, they also experience more psychological trauma symptoms, and are at greater risk for additional mental disorders that inhibit their academic development and social functioning.

Children and adolescents with emotional and/or behavior disorders tend to score below average on achievement tests, are more likely to fail one or more courses, have high absenteeism from school, and are less likely to acquire post-secondary education and job training leading to higher rates of unemployment and arrest (with as many as 58 percent being arrested at some time, either as juveniles or young adults). Nationwide, it is estimated that 42 percent of youth diagnosed as seriously emotionally disturbed earn a high school diploma, as opposed to 50 percent of all youth with a disability and 76 percent of all students. National studies indicate that only about 11 percent of seriously emotionally disturbed students in regular classrooms receive help with behavior management, with about 33 percent receiving personal counseling or therapy (Hebbeler, K., 1993, *A Special Topic Report from the Natl. Longitudinal Transitional Study of Special Education Students*). If students who are seriously emotionally disturbed are not receiving mental health services at school, are they receiving services at all?

These findings present a number of challenges for Ohio's mental health system:

1. We must work within a system that has traditionally been focused on serving children and youth with the most severe mental illnesses, primarily as a result of limited funding, but also due to insufficient research regarding effective strategies for providing prevention and early intervention services.
2. We must respond to the growing awareness among policy makers, educators, child welfare professionals, juvenile judges, mental health professionals, and the general public about the role that mental health plays in the healthy social and emotional development of young children.
3. We must try to balance addressing the needs of children and youth with the most severe illnesses while also moving toward a prevention/early intervention model that reduces this number in the future.
4. We must try to do both—intensive treatment and prevention/early intervention—with little or no new funding.
5. We need to redesign the delivery system from a clinic model to one that provides services where the children and adolescents spend most of their time—in schools, child care centers, and homes.
6. We need to collaborate with other agencies and organizations—the early childhood community and the many programs under this umbrella such as Head Start and Early Start; schools; substance abuse providers; the child welfare system and its providers, including foster parents; and the juvenile justice system, including juvenile judges and parole officers.
7. We need to move to a results-based accountability system with documented success based on hard evidence—and we need to do so within an over-stressed funding structure without adequate data to support strategic decision making.



At the same time, opportunities exist to address several of these challenges. There is a growing body of research, as documented in the Surgeon General's Report, about what works both to treat children and youth with severe emotional disorders and to prevent or reduce the likelihood of emotional and behavior problems down the line. Creation of "centers of excellence" to identify and aid local mental health boards and providers in implementing evidence-based practices is a crucial step in the right direction.

Another opportunity is the willingness among many of the state's other child-serving systems to become partners with those in the mental health community to ensure that children, youth, and their families get the help they need to begin and finish school, and to go on to become successful adults. The Family Stability Incentive Fund, the Early Childhood Mental Health Initiative, and the Alternative Education Initiative are all examples of interagency efforts to address the comprehensive needs of children and adolescents with emotional and behavior problems. Each of these initiatives also is beginning to show promise of success in changing where and how mental health services are delivered. For example, local partners in the Early Childhood Mental Health Initiative will be working in child care centers, homes and Head Start programs. Providers who are partnering with schools under the Alternative Education Initiative are working on-site in alternative education programs and other school buildings to assist youth who are transitioning into adulthood.

CHANGING LIVES

Tommy suffered continuing sexual and physical abuse during the first six years of his life. He and an older sister with the same experiences ran away from home three years ago when he was only six, and both ended up at the local children services agency. Neither Tommy nor his sister had any previous contact with a medical or mental health agency.

Today, Tommy is living with his fifth foster family in another county because his own rural county has no residential services for children. He has severe behavior problems including uncontrollable aggression, precocious sexual activity, and inappropriate toilet behavior. On four occasions, he has been hospitalized because of his out of control behavior. Each of the hospitalizations has been brief and following the last one, he was placed in residential treatment where he has begun to make progress.

But Tommy's progress continues to be slow, in part due to a shortage of services for severely disturbed children in his rural county. On one

occasion, he was discharged from residential treatment because of financial pressures in his home county. He has changed schools seven times and he is still learning to read. Presently, he is seeing a college level counselor for weekly sessions and is on multiple medications, but his foster parents are uncomfortable giving him medication, and they find it difficult to take him to a laboratory for necessary blood tests. His only important relationship is with his sister who is placed in another county and whom he sees briefly on holidays.

LESSON: The challenges of providing critical services to severely disturbed children are formidable: The lack of outreach services to identify children at high risk; the paucity of intensive residential services for children in many areas of the state; the unfortunate role of limited financial resources for child mental health; the great demand for graduate mental health professionals; and the fragmented nature of the children's mental health system

4

Access Finding: *Access to mental health services for children with a mental, emotional or behavioral disorder is substandard. Services are not provided early enough, where children and youth need them, or in sufficient supply. Worse, only a fraction of children and youth with a mental illness and severe impairment get the services they need.*



Recommendations:

- A.** ODMH and the mental health community should determine an appropriate balance between treating children and youth with the most severe mental illnesses and providing prevention and early intervention services.
- B.** ODMH should work with mental health system partners and other stakeholders, including juvenile judges, child welfare professionals, educators, parents, and early childhood providers to improve access to services where children spend most of their time. This strategy must include true shared funding of prevention and early intervention services, as well as special attention to young persons transitioning to the adult mental health system.

Access Issues Impacting Adults

Access to mental health services is also a serious problem for adults. More than 28 percent of adults will experience a mental health or addictive illness in any given year, and only one in five adults with an illness will receive treatment (Surgeon General's Report).

Consumers and families indicate that it is difficult to find out about services. Access to state-of-the-art medications, counseling and other therapies to decrease symptoms, promote recovery and avoid hospitalization is becoming more difficult in Ohio. For financial and other reasons, many local communities lack the capacity to implement a full array of effective programs. There are cultural barriers to access. Serious mental illness usually results in poverty and dependence on public support.

Access to employment is a critical issue affecting adults with a mental illness. Mental illness often leads to lifelong joblessness, homelessness, and poverty. More than 90 percent of people with a severe mental illness are unemployed, despite the fact that many consumers themselves say that employment is their primary recovery goal. Severe mental illness often causes people to lose their job and their health insurance or never have the opportunity to pursue employment or a career. The result is a downward social and economic spiral that makes recovery difficult. To continue receiving publicly funded services, the person often must remain poor and jobless.

Medicaid eligibility helps a person pay for the mental health services he or she needs. But it also perversely forces the person to stay poor in order to continue receiving benefits. The Medicaid spend-down provision, which charges some consumers a portion of the cost of care (in theory increasing the number of people that can be covered), creates an unintended obstacle to employment. For people who are looking for work, supportive services are scarce and getting scarcer. Due to severe federal budget cutbacks

effective in 2002, the Pathways Program, which provides job training and referral services to people with a mental illness, will be eliminated. The effect of this cut will be a loss of \$6 million worth of services to approximately 3,000 people.

Much work must be done to remove all barriers to employment, but the work must start within the public mental health system, which itself does a poor job of promoting employment for the people it serves. Mental health services are often inflexible and difficult to access for people who are working. ODMH and others within the mental health system have a very low rate of hiring consumers. Employment must become a key recovery goal of the system.

5

Access Finding: *Low employment rates for people with a mental illness is a statewide problem. Consumers want to work but currently receive little employment support and face a series of obstacles.*



Recommendations:

- A.** Ohio should eliminate Medicaid disincentives to employment and implement by 2002 buy-in options that were recently approved through federal Ticket to Work legislation.
- B.** The public mental health system should improve the rate of hiring qualified people with a mental illness.
- C.** ODMH and local mental health boards should invest in programs that support employment for consumers.
- D.** Mental health services should be flexible to account for the schedules of consumers who work and who are transitioning to work.

Access to adequate, decent and affordable housing also is a key to recovery for people with a mental illness. Unfortunately, the amount of housing available statewide for people with a serious mental illness does not meet the need, and the quality of the housing that is available is often substandard. Adults with a serious mental illness are at the bottom of the housing marketplace and at great risk for homelessness. At the same time, the burden of providing housing for people with a mental illness is growing for state and local authorities. Federally funded production of low-income housing has plummeted. Federal Section 8 housing vouchers have not kept pace with the demand or the marketplace, and Medicaid will not pay for residential care for persons with a mental illness. Additionally, federally funded low-income housing is being converted to market-rate housing as the initial 20-year obligation and financing commitment expires. Ohio leads the nation in potential exposure to this problem. All of this is occurring in an environment in which rental and housing costs are rising.

State and local officials must also do more to focus on housing stability, quality, and safety issues. ODMH awarded more than \$6.5 million in community capital grants to local communities in 2000. The mental health system has also worked with the Departments of Aging and Health and their local systems on an initiative to tighten the requirements for Adult Care Facilities that provide care for people with mental illness, many of whom receive Residential Support Supplement funds from the Department of Aging. But in many neighborhoods, the housing that is available for people with a mental illness is deplorable. Housing is in fact a key to recovery, but it must be decent, livable, and affordable. The mental health system has a responsibility to improve the current conditions.

Access Finding: *Lack of access to safe, adequate, and affordable housing is a barrier to recovery for many people with a mental illness.*

Recommendations:

- A.** Governor Taft and the Ohio General Assembly should advocate for federal support for and reform in HUD, Medicare, and Medicaid to improve the access, quantity, and quality of housing and support services for Ohioans with a mental illness.
- B.** Ohio's mental health system should focus on providing a continuum of housing opportunities for people with a mental illness and improving the quality of housing that is currently available.
- C.** ODMH policies and funding strategies should be made flexible enough to support a variety of housing options.
- D.** The public mental health system should work with local public housing authorities to eliminate discrimination against people with a mental illness who have a "forensic status."

CHANGING LIVES

A young man with bipolar disorder (manic depressive illness) recently discharged from the state hospital is brought to the mental health center for his first scheduled visit with his psychiatrist. While hospitalized, Herbert's medication was changed twice to maximize his response. During his interview, he acknowledges no problems with taking his medication as prescribed. The case manager reminds him of their conversation prior to seeing the physician, where he admitted that he stopped taking his medication six days earlier.

The psychiatrist, who received no word from the hospital about a medication change, is then able to determine that the client was unable to sleep for the last 72 hours and was highly irritable. The young man agreed to resume his medication and meet with his case manager in two days for follow up. Four weeks later he met again with his psychiatrist and was doing well.

Two years later and after having moved to a different county, Herbert again became ill and was hospitalized. In his new community, the mental health agency is not permitted to bill

Medicaid for case management services when the client is being seen by a psychiatrist. In his routine visit with the psychiatrist, Herbert claims to be taking his medication and meeting often with his case manager. Unfortunately, within the last six months since hospital discharge, he has been assigned three different case managers. The clinician, however, senses a change in Herbert, but having heard no concerns from the young man, refills his prescription and agrees to meet again in six weeks.

One week later, the newest case manager, who was not yet familiar with her caseload, informed the psychiatrist that Herbert had become ill again and was committed to the state hospital.

LESSON: There are unintended consequences when financial pressures interfere with appropriate care in a mental health agency. The most helpful intervention for Herbert during his second episode could not be provided because of arbitrary billing rules and regulations. Moreover, rapid turnover in community mental health center staff impeded the continuity of care for this young man.

Access Issues Impacting Older Adults

Older adults (over the age of 65) in Ohio and nationwide are living longer today, and as baby boomers age the older adult population is expected to grow considerably. For example:

- In 1999, people older than 65 represented 12.7 percent of the population. In 1940, this same group represented only seven percent of the total population. This population is expected to continue to grow in future census counts.
- In 1990 (the most recent year that figures were available), people older than 85 represented 1.2 percent of the population. In 1940, this same group represented 0.3 percent of the total population. This population also is expected to continue to grow in future census counts.

With improved diet, physical fitness and general health, adults are reaching age 65 in better mental and physical health than ever before. Trends show that the prevalence of chronic disability among older people has declined steadily in the past two decades. While some cases of disability can be traced to declining physiological functioning due to aging, extreme disability related to mental disorders is not an inevitable part of aging (Surgeon General's Report).

Older adults have unique and serious mental health access needs. Older adults often experience increased frequency of dealing with loss—such as illness and death of family and friends, and loss of memory and physical function—which may trigger depression. Other factors that can influence mental well-being of individuals at any age, but that are of particular concern to older adults, include nutrition, alcohol use, prescription medications, over-the-counter drugs, nutritional supplements, and the type and amount of exercise.

Research shows that older adults generally respond well to mental health care in a variety of settings, including community mental health centers, nursing homes, senior centers, and health clinics. However, according to research conducted by the National Technical Assistance Center for State Mental Health Planning (*Utilization of Specialty Mental Health Services by Older Adults: National and State Profiles*, Oct. 1998), more than one half of older adults in need of mental health services are not getting the treatment they need. Ignoring mental disorders, especially depression, in older adults can have serious consequences. The rate of suicide is higher in older adults than in any other age group. One in four suicides is committed by older adults. Suicide rates increase with age, with older men having a rate of suicide up to six times higher than that of the general population (Surgeon General's Report).

There are several specific factors that negatively affect older adults' access to mental health services.

- **Stigma.** Many older adults resist treatment for depression and other disorders because their association with mental illness is based on negative images frequently propagated by the mass media and popular culture.

- **Ageism.** Myths and misperceptions about older people by the public, the media and professional health and mental health providers have also affected mental health service delivery to older adults.
- **Unique and Difficult Challenges Related to Age.** Detection of mental disorders in older adults is complicated by high co-morbidity with other medical disorders. The symptoms of mental and physical illnesses may mimic each other, making diagnosis more complicated. For example, recognition of depression can be difficult because the elderly often experience and report physical symptoms that are compatible with somatic and psychological illnesses.
- **Primary Care Physicians.** Generally, the first person older adults turn to for help with problems that require mental health treatment is their primary care physician. But these physicians are often poorly trained to deal with mental health problems in older adults. Because general practitioners play an important role as provider and gatekeeper for mental health services, new educational initiatives for this group are critical.



7

Access Finding: *Factors such as stigma, ageism, and lack of awareness are barriers to older adults seeking and receiving the mental health services they need. There is mounting evidence about the value of prevention and intervention in the older population. Breaking down the barriers to access will have a profound effect on improving the wellness and well-being of older Ohioans.*

Recommendation:

- A.** Information about mental illness, and particularly depression, that is tailored to older Ohioans and made available through entities that serve older adults should be part of anti-stigma and suicide prevention efforts in Ohio.

Furthermore, the public mental health system is poorly equipped to accommodate the service needs of older Ohioans with a serious mental disability. This will present a monumental access challenge as baby boomers age. Access must be improved for adults with a severe and persistent mental illness who are “transitioning” into their later years. Also, as an adult ages, he or she often begins to receive services in new settings that are designed to serve older adults (i.e., a nursing home). The mental health system must play a positive role in supporting a person’s transition into a service delivery system that is designed for older adults. This “transition” has been neglected for a long time, and this neglect appears to be leading to a crisis. The Commission recommends that ODMH take the lead in working with mental health and other system partners to further discuss and make recommendations for addressing this specific problem.

Access Finding: *The mental health system does not meet the current needs of older Ohioans, nor is it prepared to care effectively for the large number of aging baby boomers with severe and persistent mental illness.*

Recommendations:

- A.** The public mental health system should develop and implement age-appropriate mental health services for aging adults with a severe and persistent mental illness who are currently receiving public mental health services.
- B.** The public mental health system should integrate medical services for aging adults into existing mental health regimens.

Quality and Effective Services



Providing access to care for consumers is the most basic responsibility of the mental health system. But access to services alone will not improve the mental health of Ohioans. Services must meet individual needs, they must be comprehensive, they must be delivered in a clinically and culturally competent manner, they must be reasonably convenient for the consumer, and they must promote recovery objectives that are identified in collaboration with individuals and their families. They must meet standards of quality and be consistent with research evidence. They must not be simply what is easiest or most convenient for the system to offer—or simply what’s “on the shelf” at the local mental health “store.”

The Commission realizes that funding constraints, federal program restrictions, and a host of other issues, including the challenges of diagnosis and treatment for mental and behavioral disorders, make consistent delivery of quality services challenging. Several factors that are obstacles to providing quality services are discussed in this chapter and throughout this report.

Evidence reviewed by the Commission suggests that in too many cases, service needs are not currently being met. Unemployment remains high, school success rates are low, and homelessness is all too prevalent. Access to services (i.e., “getting in the front door”) is a problem, but those who *are* able to access services cannot always count on getting the best possible care. Improvement is a responsibility that is shared by the entire system.

The ongoing Longitudinal Consumer Outcomes Study conducted by the ODMH Office of Program Evaluation and Research is perhaps the best review of the extent to which the public mental health system is meeting the needs of consumers with a severe mental illness. This survey has included five waves of measurement over the last decade, with the most recent report being distributed in 1999. The study has been conducted in two urban and two rural board areas and has included more than 550 participants. The study has 10 major findings (listed on page 28).

Top Ten Findings: Longitudinal Consumer Outcomes Study

1. Consumers' perceptions that their needs are met are the best predictors of positive outcomes. In order to improve consumers' outcomes, service providers must attend to individual consumers' perceptions of what services are needed and the extent to which consumers think their needs are being met.
2. The top two unmet needs identified by consumers are (1) vocational assistance and (2) finding out about services. According to the study, consumers have unmet needs in the following areas (ranked on a five point scale in the order of importance):

Need	Mean Difference (help needed minus help received)
Vocational assistance . . . . .	.46
Finding out about available services . . . . .	.33
Making friends . . . . .	.27
Medical and dental care . . . . .	.20
Educating others about their problems . . . . .	.19
Talking about problems . . . . .	.18
Legal issues . . . . .	.17
Benefits and income support . . . . .	.15
Complaining about services . . . . .	.14
Interpersonal difficulties . . . . .	.01
Housing . . . . .	.01
Transportation . . . . .	.01

3. Consumers and case managers have different perceptions of met needs. Consumers' perceptions of needs are better predictors of mental health outcomes than are case managers' perceptions of needs. Case managers reported unmet needs for consumers in these areas (ranked on a five point scale in the order of importance):

Need	Mean Difference (help needed minus help received)
Making friends . . . . .	.41
Vocational issues . . . . .	.23
Interpersonal issues . . . . .	.18
Managing money . . . . .	.13
Legal issues . . . . .	.01
Managing medications . . . . .	.01
Help with day-to-day things . . . . .	.01
Medical and dental care . . . . .	.01

4. Consumers' perceptions of their level of service empowerment (e.g. their involvement in treatment planning and decisions about services) is the variable most highly correlated with the degree to which they felt their needs were being met. As indicated in Finding #1, getting needs met has the greatest impact on positive outcomes.
5. Consumers do not perceive themselves to be as empowered as they would like to be, with regard to their

services and treatment. Less than half of consumers reported that they were involved in decisions regarding their services and treatment (47 percent) or their medications (43 percent). In contrast, a strong majority indicated that it was important to have some say over their services (77 percent) and to be involved in medication decisions (76 percent). On the other hand, 70 percent of consumers felt personally responsible for carrying out their treatment plan goals.

6. Consumers who are newer to the system have different characteristics and needs. Newer entrants to the study have higher rates of mood disorders, lower rates of schizophrenia, lower quality of life, and more physical health problems.
7. The "employment gap" for consumers is still huge. Only 26 percent of consumers reported working or volunteering, and just 16 percent reported that they received income from working. However, 59 percent of consumers indicated that it was important to work, and the lack of employment was a leading unmet need identified by both consumers and case managers.
8. Consumers' adherence to medication regimens depends on their level of involvement in decisions regarding their medications and whether they receive information about their medications and the medications' side effects. This is important because studies have shown that as many as 60 percent of consumers do not follow medication directives from their physician.
9. Consumers indicated in an open-ended question that a variety of resources help their progress toward recovery (participants could give more than one response):

Medication	31%
Self-initiated activities	26%
Family support	22%
Medical personnel	15%
Friend support	14%
Agency services/staff	14%
Spirituality	14%
Talking to someone	11%
Case managers	9%
Counselors and therapists	8%
10. Crime victimization is high among all consumers, but even higher among individuals who are relatively new to the mental health system. Thirty-four percent of the old cohort and 46 percent of the new cohort reported being victims of physical assault at some point during their lives. This type of experience often produces additional long-lasting symptoms.

Developing and Using Evidence-Based Clinical Best Practices

Throughout the past decade, there has been system reform and exciting innovations through research, however services and outcomes for consumers in the public system have not consistently improved. This is in part because bridging the gap between science and service remains very difficult, especially when constant changes and frequent crises at the service level demand energies that otherwise could be devoted to implementing broad-based quality initiatives. Ohio's devolved services delivery model also presents unique challenges to consistency of services across the state.

Continuing contributions from the field of research are needed to update the current knowledge about what works for consumers. State and local system partners must implement new clinical approaches to improve the use of clinical best practices for which there is already substantial research evidence of efficacy. They must also encourage and monitor the use of emerging best practices and promote innovation. This work must promote system-wide quality without

infringing on the responsibilities of local authorities to manage their systems.

Overall Finding on Quality: *Mental health services and interventions should reach the highest standards of quality, meet the needs of consumers, and promote recovery and resiliency. Despite pockets of excellence, the public mental health system has gaps in quality that prevent it from achieving its vision and mission.*

Clinical best practices are consumer-focused, evidence-based interventions and services that have demonstrated positive outcomes for consumers. These practices are derived from (1) rig-

orous scientific evidence, usually involving multiple controlled trials that compare one intervention with another, that has demonstrated the efficacy of the intervention or service; or (2) formal consensus by a group of experts, taking into account the existing research and experience in the area; or (3) research evidence that suggests the effectiveness of an intervention or program as an evidence-based practice but has not reached the level of rigor of multiple replications of findings.

The Commission highly recommends that ODMH work with local systems to develop an initiative to promote the use of best practices system-wide. Such an initiative must advance the use of research validated and tested best practices, while encouraging innovation and flexibility at the local level. The Commission also supports the continued development of the Ohio Mental Health Outcomes Initiative, which is being designed in collaboration with ODMH, local boards and agencies, families and consumers to monitor and measure the extent to which services that are being provided by the public mental health system promote positive outcomes for consumers.

Ohio's Best Practices and Outcomes Initiatives must be linked. To be effective, cost effective and relevant, services provided by state and local entities must promote recovery and positive results for consumers. Ohio must develop an integrated method of testing and communicating what is helpful and what is not, and the system must be accountable to consumers, families, the public, and itself for the quality of its work.

Quality Finding: *Developing and using evidence-based best practices improves the quality of mental health services and promotes recovery and resiliency.*



Recommendations:

- A.** Ohio, led by ODMH and in partnership with local systems, should develop and implement programs to encourage the use of evidence-based clinical best practices throughout the state for all age populations. These programs should encourage innovation and knowledge sharing, maximize local control and input, and use incentives to promote statewide implementation.
- B.** The public mental health system should provide equitable support and funding for system-wide, consumer-operated services and programs.

Development of a best practice initiative should recognize current and ongoing work relative to: Children and Youth, Adults, and Older Adults.

Quality Issues Impacting Children and Youth

At the core of children's services is the recognition that childhood and adolescence are unique developmental periods. Children and adolescents are legally and functionally dependent upon those around them, especially adults in significant role relationships. Therefore, services to children and youth must be specially tailored to meet the needs of children and youth and **they must include families in a key role**. Following are some, but certainly not all, concepts that are showing promise for children and youth:

- **Birth to early childhood is a critical time in development.** Brain research conducted over the past decade demonstrates that the way individuals function in their early childhood and preschool years through adolescence hinges, to a significant extent, on their experiences before age three. Neurobiology has dramatically increased our understanding of how the brain develops during the first three years of life by describing the impact of environmental and biological factors on a child's cognitive, physical, emotional, and social development. These findings are bolstered by evidence regarding the long-term effects of comprehensive early childhood programs, which include improved educational outcomes, reduced levels of criminal activity, and increased economic self-sufficiency (e.g., greater labor force participation, higher income, and lower welfare usage). Concurrently, research on child development and clinical practice has shown that nurturing relationships play a crucial role in facilitating young children's social and emotional development.

Increasing numbers of very young children with emotional and behavioral disorders are being treated with psychotropic medications (JAMA, Vol. 283 No.8, Feb. 23, 2000). This finding is remarkable in light of the limited knowledge base that underlies the use of these medications in this population, as well as safety concerns regarding potential adverse effects on the developing brain.

Strides have been made in this area with the early ***Childhood Mental Health Initiative***, which targets young children who are participating in Early Start, Early Head Start and Head Start, preschool programs, and child care programs. Through partnerships with the mental health community, caretakers of young children will have access to the supports they need to ensure the optimal development of Ohio's youngest citizens.

- ***Early identification and intervention for children and adolescents experiencing social and emotional difficulties are critical to their healthy development and future success.*** Most kindergarten teachers can identify with reasonable accuracy the children in their classrooms who will struggle through school and life. Without appropriate supports, these children are likely to fall behind in their class work, get discouraged, disrupt classes, and eventually drop out of school.

Children and adolescents spend a considerable amount of time in school. Research suggests that schools are an appropriate site to implement prevention and early intervention strategies. For example, the ***Primary Mental Health Project***, which targets elementary school children, found significant improvements in children's grades, achievement test scores, and adjustment ratings by teachers. The project uses paraprofessionals to establish a caring and trusting relationship with children and a brief objective screening measure for early identification of children in need. Teachers and other school staff play a key role in implementation of the project.

The literature further suggests that prevention and early intervention strategies focused on enhancing protective factors and reducing risk factors can have a significant impact on the healthy social and emotional development of children and youth. Ohio's move to use the ***Communities that Care*** risk and protective framework developed by Dr. Richard Catalano and Dr. Richard Hawkins is a positive step in the right direction.

The ***Alternative Education Initiative*** is an ODMH-led effort to promote implementation of evidence-based practices. A fundamental component of this Initiative is the establishment of a learning excellence center. A key function of the Center is to identify and work with alternative education programs to implement research-based strategies that will have a positive impact on high-risk students.

Another program will promote implementation of a new psychosocial intervention called ***Multi-Systemic Therapy*** (MST). MST has demonstrated significant improvements in behavior and juvenile delinquency. Its key ingredients are involvement of parents, intensity and consistency of treatment, and using the environments that adolescents are in.

Quality Finding: *There is research about what works in creating a continuum of services for children and youth experiencing social and emotional difficulties. With exceptions, evidence-based practices are not the norm throughout the community mental health system.*

Recommendations:

- A.** ODMH, together with state and community partners, should develop an incentive-based funding structure to promote implementation of evidence-based practices for children.
- B.** The public mental health system should coordinate efforts with the state's education system to improve and implement school-based education and awareness programs for students, families, educators, and staff about mental health and mental illness. This collaboration should also include evidence-based depression awareness and suicide prevention programs.
- C.** Through partnerships with the mental health community, caretakers of young children should have access to the supports they need to ensure the optimal development of Ohio's youngest citizens.

Quality Issues Impacting Adults

In general, there is much better research concerning what constitutes a best practice for adults than there is for children. As an example, beginning in 1992, the Agency for Health Care Policy and Research and the National Institute for Mental Health funded the Schizophrenia Patient Outcomes Research Team (PORT) to develop and disseminate recommendations for the treatment of schizophrenia based on existing scientific evidence. These recommendations, released in their final form in 1998, were based on exhaustive reviews of the treatment literature and focus on those treatments for which there is substantial evidence of efficacy.

From existing research, we know that there is overwhelming evidence to support the use of medication treatment and simultaneous psychosocial interventions. There is evidence to the effectiveness of consumer operated centers and services. However, research on essential supports and some key services (e.g., inpatient care and case management) is still limited or mixed. Supports (e.g., housing and income supports) are clearly essential, but poorly researched.

As for the real world use of best practices, the PORT study determined that adherence to the best practice guidelines was often poor. As an example, while most consumers diagnosed with

schizophrenia had access to an anti-psychotic medication, full adherence by the physicians in the study with the medication guidelines (including, for example, dosage and anti-Parkinsonian agents) was less than 50 percent. Compliance with recommendations for other treatments and supports—consumer and family education, peer support, vocational rehabilitation and presence of Progressive Assertive Community Treatment (PACT)—was even worse. This is especially relevant because the research on compliance with treatment recommendations was conducted in Ohio and Georgia.

With the possible exception of consumer operated services and access to newer anti-psychotic medications, specific evidence-based practices are not uniform in Ohio. Historically, there has been inadequate testing of service models and even less investment in improving quality and implementing evidence-based practices in clinical practice. However, interest is now growing in this area.

Since the passage of the Mental Health Act, the average daily resident population in ODMH hospitals has gone from just over 3,000 to around 1,200. System-wide, adults in community care are showing mixed improvement in symptoms and quality of life. However, family member satisfaction with services is generally not improving, and career and vocational outcomes remain dismal. In general, severely impaired adults receiving mental health care in the community remain extremely poor, unemployed, and uninsured, despite the positive economic climate in the state.

CHANGING LIVES

Brenda had 20 case managers and five psychiatrists in the ten years that she had been receiving services through the public mental health system. Now in her mid-30s, her medications over those years had been changed numerous times. Her case manager changed almost as often. Brenda would develop a rapport with a case manager, then discover that a new case manager—someone she neither knew nor trusted—had been assigned to her.

Then Brenda began receiving services through a consumer-operated organization. She was able to learn more about her illness and suggest a new treatment plan to her current doctor. The “voices” went away. The newer medication began to work. Over the years, Brenda had tried to return to work on at least seven occasions, both on her own and with assistance. Attempts failed for several reasons. She became frightened when she was

informed she would lose her food stamps and her subsidized housing rent would increase. She also feared that she might lose her SSI income and possibly Medicaid coverage as no employer offered her health benefits. Changes in medication and the lack of support, both in her professional and personal life, also were contributing factors.

Now, with the right medications and the right professional, personal and peer support, Brenda was successful in her efforts to return to work. Today, she is working toward full-time employment.

LESSON: The appropriate professional services and peer support play an important role in many effective recovery practices. Employment is a goal of many consumers, and finding employment can promote recovery.

Quality Finding: Consumers and families report that they are dissatisfied with their access to mental health services that are effective and individually tailored to meet their needs.



Recommendation:

A. Every community in Ohio should have treatment options that allow for consumer voice, consumer choice, and individualized treatment. Incentives should be provided to encourage consumer and family involvement in treatment decisions.

Quality Issues Impacting Older Adults

Recent research as noted in the Surgeon General's Report has produced some best practices for this population. For example:

- Newer anti-psychotic medications present a much lower risk of significant side effects.
- Attention to depression, anxiety and other mental disorders often reduces the functional limitations associated with concomitant mental and somatic impairments.
- A randomized study of counseling and support versus usual care for family caregivers of patients with Alzheimer's disease found the intervention to have delayed patients' nursing home admission by more than 300 days.
- Approximately 95 percent of older adults live in the community rather than in institutions such as nursing homes. Most older persons prefer to remain in the community and maintain their independence. This puts pressure on state and local systems of care to provide community-based services for older adults. In Ohio and in other states, these services are often fragmented. (This will be discussed further in the next chapter.)

The public mental health system plays a much smaller role in the delivery of services to older Ohioans than it does for children and younger adults. It is imperative that the mental health system become more active in serving seniors and emphasize best practices.

A family physician is usually the first person an older adult will turn to for help with a mental health problem. Because older adults generally visit primary care physicians more frequently than do people from other age groups, these professionals are also in a better position to detect symptoms of depression and other mental disorders.

But many primary care physicians have limited training in the care and management of geriatric patients. Many also lack the training necessary to identify mental health problems. This point is highlighted by statistics in the Surgeon General's Report relative to the rate at which primary care physicians are successful in recognizing and treating depression. In one study of primary care physicians, only 55 percent of internists felt confident in diagnosing depression, and even fewer, 35 percent, felt confident in prescribing antidepressants to older persons. Studies estimate that 70 – 75 percent of older adults who complete suicide see their physician within a week prior to committing the act. (Yeats Conwell: *Management of Suicidal Behavior in Older Americans*)

In one study of primary care physicians, only 55 percent of internists felt confident in diagnosing depression, and even fewer, 35 percent, felt confident in prescribing antidepressants to older persons.

Assessment of mental disorders in older adults is often difficult. Many older adults are reluctant to disclose psychological symptoms. Mental disorders in older adults also frequently co-exist with other medical disorders. Additionally, older adults pose some unique challenges that influence the effectiveness of treatment once the person is diagnosed. These factors include increased vulnerability to medication side effects and barriers to compliance with treatment protocols—all

CHANGING LIVES

At 73, Elizabeth lives by herself, with little access to public transportation. She was brought to the family physician by her neighbors, who were concerned about changes in her behavior and appearance.

A former teacher, Elizabeth lost her husband nearly 2 years ago. The neighbors have been concerned about her social isolation and refusal to participate in activities that she had previously enjoyed. They have noticed that she no longer uses makeup, something that she always took great pride in. The woman tells her family doctor that she feels well, except for insomnia and nervousness. She is diagnosed as having an anxiety disorder and prescribed a tranquilizer.

Elizabeth neglects to inform her physician that she has been taking over-the-counter sleeping medication for approximately 6 months. She occasionally forgets that she has taken prescribed medication and follows it therefore with a second. One week later she is taken to the emergency ward by her neighbors and appears to have significant problems in her thinking. She is noted to have difficulty with

her attention, her recent memory is impaired, and she appears to be agitated. The hospital social worker is called to secure a bed in a nursing home because the physician believes she is demented.

Two months after her transfer to a nursing facility, she is evaluated by the consulting geriatric psychiatrist who diagnoses her as having severe depression brought on by the death of her husband. He takes her off all medication and within 48 hours she is much clearer in her thinking. Elizabeth is then able to describe in detail that she had been feeling sad, lonely, desperate and often wishing that she were dead. She was started on antidepressant medication and discharged that same week for follow-up care at the community mental health center.

LESSON: Many elderly citizens are reluctant to seek mental health care. They rely on the primary care physician for all care, even though it is often difficult to diagnose mental illness in an older patient. Segmented services in this age group have significant costs and consequences for communities.

Quality Finding: *Lack of knowledge about diagnosing and treating mental illness in older adults is a major barrier that prevents them from receiving appropriate care and effective treatment from primary care providers.*



Recommendation:

A. ODMH should work with the Department of Aging, Ohio medical schools and continuing education programs to better educate and train primary care practitioners about diagnosis and treatment of mental illness in older adults.

of which are exacerbated by the fact that most older adults take multiple medications for physical as well as mental illnesses. Working closely with older adults to break down these barriers is crucial to providing them with the services and interventions they need.

Other people, such as retirement home professionals, nurses and members of the faith-based community, also fill important gatekeeper roles for older adults. Interventions for reducing the risk of developing, exacerbating, or experiencing the consequences of a mental disorder are valuable and can be implemented by any of a number of gatekeepers. Because many disorders, especially depression, are triggered by loss, grief counseling and family and caregiver support systems are important prevention techniques. Services must be offered in settings that the older adults are likely to use.

Improving Individualized Care Through Cultural Competence

As stated previously, providing services that are tailored to meet individual needs is fundamental to service quality and recovery. Cultural competence is a key to providing individually tailored services to all people, but particularly to those with diverse backgrounds. The concept of cultural competence is gaining prominence in Ohio and across the country, but it is often misunderstood and underutilized.

To fully appreciate how cultural competence can enhance individualized care, it is useful to understand several core definitions:

- **Culture** is the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, age, or social groups and demographics.
- **Competence** implies having the capacity to function effectively.

- **Cultural competence** is a set of congruent behaviors, attitudes and policies that integrate within a system or agency, or among professionals, and enable that system, agency or professional to work effectively in cross-cultural situations.

Cultural competence means that interventions with an 80-year-old woman with depression must be different than interventions with an eight year-old boy with depression (regardless of race or ethnicity). Cultural competence allows professionals and organizations to understand and integrate into treatment planning unique differences among all people, especially those of diverse ethnic, racial, religious, age, and social groups. Cultural competence promotes access, compliance with treatment, and recovery.

Culturally diverse populations have historically experienced disparate access to appropriate mental health services. Data from Ohio in the 1980s showed an overuse of more restrictive services (e.g., more severe diagnoses and intensive treatment) by African Americans, particularly African American males, while community care (outpatient and community support services) was less utilized. Since 1991, a number of entities in Ohio have come together to address these issues. The Minority Concerns Committee, comprised of agencies, consumers, providers, and boards, was established by ODMH to study the utilization of services. Its reports in 1988 and 1992 were used as the impetus for developing a strategic plan for use in Ohio's mental health system.

CHANGING LIVES

After visiting a mental health center for a number of years, William was considered to be treatment resistant. In fact, he had been discharged from treatment on several occasions. He then became a participant in the Cultural Competence Project. He continued with case management services at the center, although his case manager rarely saw him and never visited him in his home.

The case manager came from a middle-class background and was a very petite white female. She feared and mistrusted William, in part due to stereotypes about black males being violent and dangerous.

William was a large black male who feared and mistrusted his case manager, again based on his perception of white women being manipulative and falsely accusing black men of criminal activity. Additionally, he felt that he had not been treated well by the mental health system.

The case manager began visiting William at the Project, and with open discussions that included Project staff and other participants, both discovered that their fears were unfounded. A safe

haven was provided for both the case manager and the client to talk about their differences and move towards a common place of comfort which then opened the door for the client to get the services that he needed.

As a result of this encounter, the case manager began working with William based on his needs, not her perception of him. She was able to find him better housing, get him into a vocational program and began to see him on a regular basis to deal with his mental illness. William ended up with a better relationship with his case manager. He felt that he could depend upon her, and he became more comfortable with her. He began going to her office and sensed that his clinical needs were being met. He has remained in treatment, has experienced no further hospitalizations or incarcerations as a result of this improved relationship and the conflict resolution efforts provided by the Project.

LESSON: Culturally competent services improve the quality of interventions and can change people's lives.

Since 1994, funding has been provided to local systems for the development of culturally competent programming. The results of these funding efforts have been mixed, with only a small number of projects using local funding to maintain successful components of the original program. Unfortunately, overall access to appropriate and/or culturally competent services is not optimal. On a broader level, the Surgeon General's Report takes special note of the mental health system's inability to meet the needs of ethnic and racial populations. This and other related issues are expected to be discussed in more detail in an upcoming supplement to the Surgeon General's Report.

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Quality Finding: *Cultural competence is a key component of service quality. Unfortunately, evidence-based practices that are culturally competent are not uniformly practiced in Ohio's public mental health system.*



Recommendations:

- A.** The public mental health system should continue to expand efforts to promote, encourage, and develop mechanisms that will result in increased access to culturally appropriate mental health services for all Ohioans.
- B.** ODMH should work with local boards and agencies to develop an assessment tool to help local systems conduct a thorough assessment of cultural competence, to develop recommendations and to identify resources for service improvement.

Ohio Access Review and Recommendations

*G*overnor Taft recently established the Ohio Access Initiative, under which the state human services agencies, including ODMH, must conduct a comprehensive review of Ohio's services and support systems for people with disabilities and make recommendations for improving services to this population over the next six years. This review must include the identification of the needs of severely mentally disabled adults who may be inappropriately served in institutions or who experience disruption in community living because of inadequate services and supports. The Ohio Access Initiative is consistent with the reviews occurring at the federal level in response to the recent U.S. Supreme Court decision in *Olmstead v. L.C.*, which found that people with a disability have a right to services in the least restrictive environment.

ODMH requested the Commission's help with doing this review. Public comments on this topic were received during the forums. The Commission reviewed the public comments and solicited independent advice in developing its Ohio Access-related findings and recommendations. Initial work on some of these recommendations has already begun.

Ohio Access Initiative: Review of Need

Research published in 1990 (Taube, Morlock, Burns, and Santos) indicates that approximately 20 percent, or 11,600, of Ohio's population of 58,000 severely mentally disabled adults currently receiving treatment require continuous, intensive treatment over several years or more. Providing safe, stable and, in many cases, supervised housing is essential for this population. This is the same population that ten years ago would have spent considerable time in state hospitals, either continuously or for months at a time.

While the Mental Health Act reform measures of the 1990s have largely been successful, there are a number of persons in this "most in need" category whose needs are not being adequately met because services of appropriate intensity and support systems with sufficient organizational integrity have not been made available. Without adequate services and supports, these individuals are at risk for significant disruption in their lives and are at greater risk for frequent crisis episodes, substance abuse, homelessness, being jailed for minor misdemeanors attributable to psychotic behavior, decline in physical health (with increased health care costs), and sometimes physical injury and death.

As part of the review of the publicly funded mental health system and services required under the Ohio Access Initiative, the assessment of the approximate 11,600 most severely mentally disabled adults reveals the following:

- More than 100 severely mentally disabled adults remain hospitalized for long periods of time (i.e., greater than six months) who could more appropriately be served in community settings if intensive services and housing supports were made available.

- Approximately 300 severely mentally disabled adults residing in adult care facilities for long periods of time could be more appropriately served in a community-based setting if intensive services and housing supports were made available.
- Of the remainder of the “most in need” population, approximately one-third, or 3,700 persons, are not adequately served in the current community mental health system. The estimate relies on indicators of frequency of psychiatric hospitalizations and crisis episodes in an annual period. Deficiencies exist in the community system in clinical and rehabilitative services as well as in specialized housing supports. Additionally, more than 1,400 persons with a mental illness are discharged from Department of Rehabilitation and Correction Facilities each year.

Ohio Access Initiative: Proposed Action Steps

The problems outlined above can be addressed through two integrated program initiatives: (1) PACT Teams and (2) Specialized Supported Housing.

- **PACT Teams.** PACT, an acronym for a well-researched treatment model named Program of Assertive Community Treatment, has been implemented on a statewide basis in 15 states, including Michigan, Illinois, New Jersey, Texas, and Wisconsin. PACT is a highly structured, multidisciplinary program of intensive treatment, rehabilitation, and support services to clients in their homes, on the job, and in social settings. It is designed only for those “most in need” severely mentally disabled adults described above.

Research has shown that use of the PACT model will result in decreased hospitalizations, shorter lengths of stay, increased employment, less severe symptoms, and more positive social relationships. That same research has shown, however, that for any PACT program to be successful, critical elements of the PACT model must be strictly adhered to. Program standards, including staff mix and qualifications, minimum staff-to-client ratios, treatment protocols, and program operations must be well-specified and monitored to assure program integrity and accountability. Financial incentives must be properly aligned as well. Those states that have had the most success have assured that state funds and Medicaid coverage are structured and allocated in ways that provide incentives for local areas to organize their existing systems and services to support PACT implementation.

ODMH has already begun the groundwork for PACT implementation. Essential initial tasks include the following:

- Identifying boards that have shown a clear need for PACT development and have an interest in beginning the work necessary to reconfigure local systems to accommodate this model. This initiative proposes the conversion of local services to the PACT model, not stand-alone new funding.
- Establishing, through developmental pilot efforts, the operational and program standards necessary to certify local PACT programs, and the monitoring and review mechanisms to assure fidelity to the PACT model.

- Establishing Medicaid coverage (bundled PACT service), rate structure (monthly rate), and enrollment criteria (no payments for services to persons not enrolled) necessary to support these programs.

Eight months of developmental activity would allow ODMH, in partnership with community mental health systems, to implement 32 PACT programs in FY 2002-2003. Twenty of these programs would be in urban and larger board areas, and 12 would be in rural board areas. The urban programs would be able to enroll an average of 110 persons per program, and the rural programs would be able to enroll an average of 55 persons. In total, the proposed programs would serve approximately 2,800 “most in need” adults of the total 4,100 target population.

■ **Specialized Supported Housing.** The medical and rehabilitative interventions afforded through the PACT model will not be effective unless a stable living environment is available. The average housing assistance program subsidy is not sufficient to meet the specialized housing supports needed by the most vulnerable mentally ill Ohioans. However, access to safe, stable and affordable housing in Ohio for persons with serious mental illness is problematic. Therefore, identification of specialized housing needs will be an integral part of the PACT program implementation. A program successfully developed in Stark County that promotes special lease arrangements and staff assistance to ensure client compliance with the lease would be considered as a model.

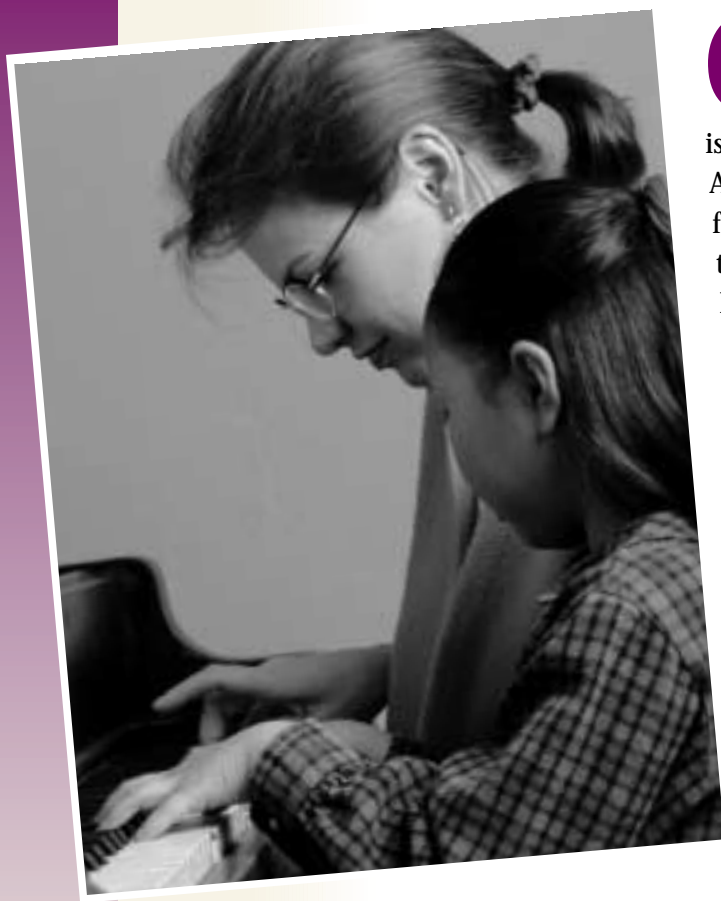
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Quality Finding (Ohio Access): *It is estimated that approximately 4,100 of Ohio's 58,000 severely mentally disabled adults either remain institutionalized or experience substantial disruption in community settings because services of the required intensity and structure are not available.*

Recommendations:

- A.** ODMH should provide funding and make clinical knowledge available to help local boards convert to the research-validated PACT model of services and local delivery system structure for persons in need.
- B.** The Taft Administration should support amending Medicaid coverage rules to enhance PACT services (e.g., monthly billing rate for services to enrolled persons in need).
- C.** Ohio should ensure that effective models of supported housing, appropriately integrated with PACT services, are available to this population.

IV System Design, Function & Integration



Ohio's public mental health system has been reconfigured to comply with the Mental Health Act of 1988. Ohio's system is now managed locally by 50 CMH and ADAMHS boards, with support and oversight from ODMH. State and federal funds flow through ODMH to the local communities. Boards purchase mental health services from independent community mental health providers and from ODMH-operated behavioral healthcare organizations. Ohio's approach of a cabinet-level state mental health agency and strong local control is the strongest model in the country.

However, many problems remain that inhibit the system's ability to meet its mission and vision. Among these are the following:

- The public mental health system should continue to improve efficiency and effectiveness, and to operate as a single system that collaborates at the state and local levels to meet the needs of consumers.
- Consumers and families face bewildering complexity in accessing services, especially for children and adults. The challenges of finding the right treatment are made more difficult when multiple systems are involved.
- State-level requirements that are designed to ensure quality services by specifying "minimum standards" are too often a burden on providers. This red tape creates a costly burden for local systems whose staffs are already stretched too thin. Resources used to meet regulatory requirements often could be better focused on providing direct care.
- Mental health remains a multi-tiered system. On one hand, private insurance plans and government share responsibility for meeting the mental health needs of Ohioans (see earlier recommendations about parity). On the other hand, the state/local public system is strongly affected by the federal government's health care policies and regulations. Ohio relies on federal support for mental health through housing and vocational rehabilitation initiatives, Medicaid, Medicare, special education, and Social Security. But these core programs are seriously flawed in terms of their impact on mental health. Federal requirements greatly limit Ohio's ability to provide comprehensive community-based care.

Overall Finding on System Design: *The public mental health system in Ohio should become more efficient relative to design, function, and integration. Inefficiencies in these areas are barriers to providing access to quality services and achieving the system's mission and vision.*

The Federal Role in Mental Health

In some aspects, the recent role of the federal government in mental health has been extraordinary. The Surgeon General's Report, the White House Conference on Mental Health, the developing work on a national strategy to prevent suicide and federal parity legislation are positive initiatives that have focussed the nation's consciousness on mental health. On the other hand, the core federal programs that states rely on to serve those with serious mental illness have generally not improved. In some cases, these programs have stepped backward. Federal program design factors greatly limit states' abilities to provide comprehensive community-based care. This is crucial because care for those with the most serious disorders has always been a state responsibility.

The Commission has recommendations in the following areas related to the federal role in mental health:

- In the case of ***housing***, there has been recent progress in the administration of Housing and Urban Development (HUD). However, a drastically reduced federal role in production of low-income housing, inadequate levels of Section 8 housing subsidies, and the dramatic conversion of existing low-income housing to market-rate housing—with more potential losses in Ohio than in any large state—have reduced the availability of safe, decent, and affordable housing for people with a mental illness, many of whom live in extreme poverty. As a result of these action and cutbacks, Ohioans with serious mental illnesses are too-often unable to access affordable housing.
- In the case of ***vocational rehabilitation***, due to ongoing design limitations in the federal program (e.g., a bias toward short-term training and placement), the rehabilitation success rate for individuals with serious mental illness is lower than for any other disability group. Yet, on the whole, more people with mental illness need this assistance than any other disability group. The combination of reduced access to affordable housing and poor vocational assistance puts vulnerable people at greater risk. This cannot be overcome without more cooperation from the federal government.
- In the past decade, ***Medicaid*** funds have been a valuable resource in the development of Ohio's community mental health system. But inflexibility in Medicaid requirements are increasingly problematic. Where Medicaid was once an asset, it is now creating crises in some areas of the state. There are several serious problems with Medicaid:
 - Medicaid will only fund a narrow range of “medically necessary” services. It does not fund many services that are essential to recovery for consumers and families.
 - Because Medicaid is an entitlement program, local systems cannot control the number of Medicaid providers or prioritize the services that are provided in their communities. Complex waivers of federal regulations requiring both state agency collaboration and federal approval are required to address these constraints. Absent any control, and because local systems are

responsible for Medicaid match (about 40 percent), Medicaid is consuming resources in local communities. This is putting some communities in a fiscal crisis. It also leaves local systems without the funds to provide services that are not covered by Medicaid.

- The federal Medicaid program does not cover care in psychiatric facilities for persons aged 22-65. This so-called “IMD exclusion” deprives the state of funding for hospital care. Just as critically, it limits access to “Home and Community Based Services “ waivers that have been used successfully to serve developmentally disabled and elderly individuals.
- The problems inherent in fee-for-service (unmanaged) Medicaid mental health reimbursement include the facts that only some mental health clients are eligible for Medicaid, only some of the services they require are covered, and fee-for-service billing is very expensive. Managed care approaches under Medicaid waivers can help with some of these problems, but they have other serious limitations. The fact that Medicaid covers only some consumers and just a portion of mental health services means that managed care arrangements tend to create gaps in care. Additionally, benefit design limitations and the IMD exclusion tend to lead to low and potentially inadequate mental health capitation rates.

System Design Finding: *Federal requirements and restrictions on Medicaid services constrain the public mental health system’s ability to provide services that consumers and families want and need.*



Recommendation:

- A.** The Taft Administration should advocate for fundamental changes in the Medicaid program to better serve people with mental illness.

There are several additional dimensions of the federal role in mental health that must be improved:

- **Medicare** is problematic for people with a mental illness because of the absence of a medication benefit. Medications are often the first line of treatment for mental disorders. Additionally, Medicare’s coverage of inpatient and outpatient mental health treatment is not on par with coverage for treatment of other illnesses.
- The federal government has imposed mandates on states to provide for ***special needs students***. But these mandates have not translated to adequate services at the local level where these students attend class—in part because the federal government has picked up only about one-third of its promised 40 percent share of special education costs.

- Improving access to insurance-financed health and behavioral health care for people with a mental illness remains a challenge, especially considering the increasing burden on public systems. Where parity laws have been enacted, the federal government's preemption of state insurance regulation of self-insured plans under the ***Employee Retirement Income Security Act (ERISA)*** limits the effects of the parity measures.
- For those persons with serious mental illness who receive benefits through ***Social Security*** programs, the work disincentives have been immense. Now that we better understand the importance of a job for many consumers in their recovery process, the missed opportunities and damage to many are painfully obvious. This is one area where federal leadership in reforming a broad federal program—one that impacts those with mental illness significantly—has been exemplary. There is a strong recognition in the Social Security Administration that mental disorder-related disability is costly. Recent steps are positive. For example, recent Ticket to Work legislation should help enormously. This example of Social Security Administration reform should be used as a model in reviewing other federal programs.

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System Design Finding: *Flaws in the design of federal programs relative to housing, vocational rehabilitation, Medicaid, Medicare, special education and ERISA regulations impede Ohio's ability to meet its mental health mission and vision.*

Recommendation:

A. ODMH, Governor Taft, and the Ohio General Assembly should advocate aggressively with the federal government to correct flaws in federal programs that support mental health.

Decreasing Regulations and Red Tape to Improve Accountability, Quality and Efficiency

In the past, one major strategy to ensure quality and accountability in the publicly funded mental health system has been regulatory—defining minimum standards for performance, rather than focusing on system and clinical quality. The current approach is not appropriate for the long term because it adds unnecessary administrative costs to the system and it is responsible for an overemphasis on paperwork that reduces clinician opportunities for direct client care. The development of internet-based solutions and continually accelerating computer power create opportunities for alternative solutions.

It is critically important that ODMH continue and hasten its course of deregulating all but the most essential aspects of health and safety (e.g., incident reporting, seclusion, and restraint), and put in place alternative methods to develop system and clinical quality, accountability, and performance—while facilitating efficiency. At the same time, essential protections for consumers and families should be carefully retained. ODMH must develop an overall process of quality improvement that is functional at all levels of the system—department, boards, and providers. Consumers and family members must be given an instrumental role in this process. System and clinical quality and performance measures must be established for all levels of the system, and payer compliance criteria must be developed and followed to assure accountability. Given the inherent nature of continuous quality improvement and the rapid advances in service technology, the process, measures and criteria in such a quality improvement system may best be established through contractual methods instead of regulation.

As these alternative methods are developed, there must be a greater focus on those elements of quality and performance that are essential to assuring sound, effective local systems of care. With the completion of the structural reform of the 1990s, it is clearly evident that mental health services, particularly those services for the most severely mentally ill adults and children and adolescents, function well only in the context of a well-coordinated local system. A major limitation of current certification standards is that the standards focus only on providers, not on systems of care. Contractual methods to establish quality and performance standards for local board-managed systems must be developed. In order to assure that essential local system services and supports are in place throughout Ohio, there must be some degree of standardization of quality and performance expectations.

Finally, with the increased emphasis on contractual methods to promote and ensure quality and performance, more effective methods must be established to settle significant contractual disputes between Boards and provider agencies.

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System Design Finding: *The public mental health system must employ new methods to improve accountability and quality while reducing regulations and improving efficiency at the state and local levels.*



Recommendation:

- A.** ODMH should replace burdensome and unnecessary regulations with contractual, outcome-oriented methods for monitoring and ensuring quality.
- B.** ODMH should work with local system partners to identify and promote other initiatives at the state, board, and agency levels to improve quality and efficiency.
- C.** The public mental health system should develop a credible dispute resolution process between providers and boards, and between boards and ODMH.

Improving Integration Within the Public Mental Health System

Historically, the constituent groups of the mental health system have not always worked effectively together. The emphasis on local control and local planning, while the basis of the system and beneficial in many ways, has also led to inconsistent interpretations of policies across board areas and variability in the contractual requirements placed upon providers in different areas of the state. This inconsistency and variability has contributed to inefficient and ineffective statewide planning and service delivery, as well as conflict between some of the constituents within the system.

While in some areas boards successfully strive to work in partnership with consumers, families, and providers to plan and develop an effective local system of care, other areas have encountered difficulties in establishing or sustaining such collaboration. ODMH generally does not intervene when local system issues become problematic, and functional dispute resolution mechanisms have not been instituted to address the system problems that occur.

Much focus has been placed on ODMH, boards and providers working together in partnership to address problems, concerns, planning efforts and other issues. However, these partnership relationships have not been defined; neither have parameters for operationalizing partnership decision-making. Even when working in partnership, lines of authority, responsibility, and leadership must be clear to all parties. Often, when the Department, boards and providers are involved in an activity, it is unclear who is responsible for which task or how decisions will be made, and clarification is difficult to obtain. It is essential that the mental health system move beyond control and regulation toward a model based on partnership and mutual respect.

In 2000, ODMH sponsored the formation of a Systems Linkages Group, comprised of representatives from all the major constituents. In August 2000, the group adopted the following mission statement: *“To provide a forum for communicating about, shaping, and linking current and emerging activities and resolving conflicts in policy and implementation issues affecting the behavioral health system.”*

The Linkages Group, while a solid first step, is alone not sufficient to bring about the type of change necessary for the future of the mental health system. As currently structured, the group depends solely on the goodwill of the individual participants and has no defined method for disseminating information throughout the system, and no authority to implement suggested changes or require the participation of any board or provider in any recommended action plan. Clearly, a strategy for determining how to build upon the concept of this group and institute system-wide change in the way various constituencies work together is essential.

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System Design Finding: *Ongoing system structure and relationship issues have been inadequately and ineffectively addressed.*

Recommendation:

A. ODMH should lead a process of defining effective partnerships and contractual arrangements between itself and boards, and between boards and providers. Those partnerships should include performance measures and dispute resolution mechanisms. ODMH should develop and implement the strategy that evolves from that process, including legislation, if necessary.

System Design Issues Impacting Children and Youth

In 1982, Dr. Jane Knitzer's seminal study, *Unclaimed Children*, documented the plight of mentally ill children and adolescents "unclaimed" by the multitude of government and community agencies responsible for their care. There has been significant progress in many states and communities across the nation since that time, primarily as a result of special grants from the National Institutes of Mental Health (NIMH) through the Child and Adolescent Service System Program (CASSP) and the Robert Wood Johnson Foundation's Mental Health Services Program for Youth. Unfortunately, too few communities have created sustainable comprehensive systems that support the multiple needs generally experienced by children and youth with mental health disorders.



As stated previously, Ohio's community mental health system is composed of 50 local mental health boards and about 500 mental health providers, *many of which do not specialize in treating children and youth*. All but seven boards also administer alcohol and drug addiction services. The majority of Ohio's other child-serving systems are organized by counties. For example, the child welfare system is administered locally by either county departments of job and family services (combined agencies) or children's services boards. The child welfare system also includes a variety of child-caring agencies offering different services and a host of family foster care homes. As with Ohio's other child-serving systems, the child welfare system functions differently in each of the 88 counties. Local control and administration of these systems is consistent with Ohio's preference for home rule, but it does pose challenges that must be overcome in order to provide comprehensive and coordinated services to children.

Another major stakeholder in addressing the mental health needs of children and youth is the juvenile justice system. This system includes detention centers, probation and parole, and state facilities for incarcerated youth administered by the Ohio Department of Youth Services. Ohio's 677 school districts also play a critical role in addressing the needs of children and youth with emotional and behavioral problems. Each school district has its own policies and procedures, and is governed by an independently elected school board. Finally, there are a host of local non-profit organizations that offer a variety of prevention, early intervention, and treatment services to children, youth, and their families; most are also governed by local boards. Many of these organizations contract with local government agencies, while others are supported through United Way and other private funding sources.

Each local agency is governed by a host of state and/or federal rules and regulations, legislation, and local policies and procedures. For example, each system and each local agency has different approaches to confidentiality, financing, and interventions. Training requirements, licensing, and credentialing are as diverse as the systems themselves. On-going professional development may or may not exist. Some agencies thrive on working with other professionals; others are content to operate independently. Some agencies welcome and encourage family involvement, while others prefer to let the professionals determine what is best.

On a more positive note, several counties have invested the time, energy, leadership, and resources needed to create comprehensive systems of care for children and adolescents with mental health problems. One county has developed a system of care that involves all of the critical stakeholders, system level coordination mechanisms, and system-level management. Children and their families are at the center of a continuum of services that includes outpatient services, beginning with a multi-factored assessment and including family therapy; prevention and early intervention services such as support groups for elementary students in inner city schools; home-based services; day treatment services; crisis services; child and family advocacy; substance abuse services; respite services; and residential services.

Another mental health board has taken a slightly different approach by working in partnership with individual agencies, both public and private. For example, through an agreement with the children's services board, foster families and their children who are experiencing behavioral and emotional problems receive mental health services. The program is designed to reduce the number of disruptions in these children's lives and add stability to the lives of foster parents and children placed in their care. Through partnerships with the local United Way, the board provides home-based mental health services to families with very young children to ensure their healthy social and emotional development.

At the state level, there are three successful initiatives that are beginning to impact the way services to children and youth with serious mental illness are delivered:

- The **Family Stability Incentive Fund** was launched under the umbrella of the Ohio Family and Children First Cabinet Council in 1996. While not specifically targeted to children and youth with mental health disorders, it is designed to reduce the number of children and youth placed in out-of-home care across all child-caring systems and has succeeded in achieving this goal. While each of the participating counties has designed slightly different strategies, the majority focus on bringing front-line staff to the table with the child and his or her family to develop a comprehensive plan for addressing children's needs.
- The previously mentioned **Alternative Education Program** was launched recently to provide alternatives that both reduce disruption in schools and increase opportunities for youth who might otherwise fail or drop out of school. Mental health supports are provided in many alternative schools. The Center for Learning Excellence, an ODMH and Ohio Department of Education funded center at The Ohio State University, provides technical assistance and supports to these programs. Although the Program is new, it is signaling a different approach to achieve school success for children with learning problems or behavior disorders.

- The *Mental Health to Juvenile Offenders Project* is currently operating in three sites throughout the state. Focused on a continuum of services including secure residential placement and community-based services, the projects target youth involved with the juvenile justice system with serious mental illness. Partners at the local level include mental health, juvenile courts, substance abuse, mental retardation and developmental disabilities, and children's services, as appropriate.

C H A N G I N G L I V E S

A mother was told by her daughter's school principal that 14-year-old Jennifer required evaluation by the family physician. Teachers were concerned about recent changes in her behavior, which included failing grades, inability to complete homework, sleepiness in class and interpersonal difficulties with her peers and teachers.

The family physician suspected a psychiatric condition and referred Jennifer to the community mental health center where a social worker confirmed the diagnosis of significant depression and anxiety. The social worker indicated that the teenager must be seen for psychiatric evaluation and possible treatment with medication. But the mother was told that it would be four months before an evaluation appointment with a child psychiatrist could be scheduled.

Three weeks later, Jennifer was brought into the emergency ward by ambulance after a nearly fatal overdose. While hospitalized in the intensive care unit, Jennifer was seen by a child psychiatrist who

found that the eighth-grader was severely depressed, unable to sleep or concentrate, had lost 10 pounds in less than five months and admitted to constant suicidal feelings. The psychiatrist also learned that Jennifer's symptoms began after an attempted rape by a classmate—an assault about which she had told no one because she was ashamed and embarrassed.

In addition to medication, the child psychiatrist recommended intensive psychotherapy to address Jennifer's traumatic disorder. She was referred once again to the community mental health center for treatment, where she is finally getting the help she needs.

LESSON: Families seeking help for a troubled child too often find themselves faced with a complex assessment and treatment process, as well as an inadequate supply of trained mental health professionals. Also, providing mental health services in a non-school-based system can be challenging.

System Design Findings: *There is a dearth of quality services across all child serving systems. Unless improvements in these systems are balanced with efforts to move toward prevention, children and youth will continue to suffer. Systems improvements that are not connected to public education and improved accountability will be inadequate. Additionally, serving children and youth with mental, emotional and behavioral disorders requires partnerships among all of the state's child serving systems, including child welfare, public education, juvenile justice, and private providers. Collaboration among these entities at the local level is increasing, but is uneven and insufficient to meet growing demands.*

Recommendations:

- A.** ODMH should work with community mental health systems to identify and develop strategies to address barriers to seamless and coordinated services at the local level, including joint funding. This effort should also involve representatives from the community mental health system, child welfare, juvenile justice, and public education.
- B.** The public mental health system should build on the Governor's new commitment to school success by working through the Ohio Family and Children First Cabinet Council to realign existing services to better meet the needs of children and youth with mental health disorders.
- C.** ODMH should urge the Ohio Family and Children First Cabinet Council to consistently monitor the effectiveness of service coordination mechanisms required in state statute, share information about effective strategies, and stipulate consequences for those counties that are non-compliant.

System Design Issues **Impacting Adults**

As with children and youth, the public mental health system must coordinate with other public and private systems to meet the needs of adults with a mental illness. This is critical in providing housing and employment services and meeting the needs of people with a severe mental illness who require continuous and intensive treatment. It is also vital in working with those people who have a mental illness and interact with the criminal justice system, as well as with people who have a dual diagnosis of mental illness and either substance abuse or mental retardation/developmental disability.

Collaboration with the criminal justice system. Although four of the five most common offenses charged to persons with a mental illness are not violent crimes, persons with a mental illness are over-represented in jails and prisons. Among the general population in the United States, only five to seven percent of adults have a serious and persistent mental illness. Nationally, best estimates are that as many as 15 percent of the adults in jails and prisons have a serious mental illness.

It is estimated that more than 685,000 persons with a serious mental illness are admitted each year to U.S. jails and prisons (Steadman). In Ohio, public funds are used to treat people with a mental illness in prisons, county and local jails, and youth service facilities and other facilities. The public mental health system is responsible for providing services to people who have been accused of a crime and are found incompetent to stand trial or not guilty by reason of insanity. Today, more than half of the patients in ODMH Behavioral Healthcare Organizations are classified under this “forensic” status.

On the whole, the mental health services that are available to people in ODMH or Department of Rehabilitation and Correction institutions as a result of being accused or found guilty of a crime are much improved. Ironically, in some cases, lack of local treatment access and funding dynamics are incentives to keep consumers under a forensic, rather than civil, status. This is unfair and counterproductive for the consumer and his or her family.

In the area of criminal justice and mental health, efforts must be intensified in the following ways:

- Collaborating with the criminal justice system to provide more appropriate diversion alternatives to incarceration for non-violent offenders.
- Working with the criminal justice system and local authorities to link mentally ill offenders who are released from jail and prison with appropriate community services.
- Working with criminal justice professionals and others to facilitate appropriate response and intervention techniques for helping mentally ill people who are in distress and crisis.
- Advocating for changes in federal programs, especially in HUD and the Healthcare Financing Administration (HCFA), that currently provide inadequate services and supports for mentally ill adults, thereby increasing the risk of criminalization.

Nonviolent mentally ill persons should be diverted when possible from the criminal justice system to supervised treatment. The focus in these cases should be treatment, not punishment. Federal legislation was recently passed that authorizes funding for up to 100 pilot mental health courts across the country to provide specialized handling of these cases. Further, special attention must be given to mental health issues in all courts, in corrections, and within law enforcement. This requires a higher priority on partnerships between the mental health system and the criminal justice and corrections systems. Law enforcement, as the gatekeeper for many people in crisis, must be uniformly trained to recognize the signs and symptoms of mental illness and to intervene appropriately in these instances.

Linking people who are released from jails and prisons with community mental health services is an important responsibility for the mental health system. The Bureau of Justice Statistics estimates that 75 percent of mentally ill inmates have been sentenced to time in prison or jail, or to probation, at least once prior to their current sentence. At any given time, ODMH staff monitors more than 300 people who have been found not guilty by reason of insanity and who have been placed on conditional release to the community. In 1999, ODMH staff made more than 1,400 referrals and appointments for persons being released from prison

to be seen by community mental health agencies following release. If done effectively, linkages and continuing treatment will result in lower recidivism rates for this large population.

Ohio has taken some positive steps in improving diversion and linkage programs. ODMH recently released \$875,000 in grants for 15 separate community diversion and linkage programs throughout the state. This is a good first step, but more must be done in this area. The most critical step in enhancing diversion of people with mental illness from inappropriate incarceration to community treatment and support is to strengthen the safety net of community care, and to improve access to services and affordable housing.

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System Design Finding: *Diversion, linkage, and education programs for people with a mental illness—in coordination with adequate housing and treatment services—decrease inappropriate incarceration and recidivism.*

Recommendations:

- A.** State and local mental health systems should work collaboratively with state and local law enforcement to adopt education and training models for intervening with people with a mental illness.
- B.** On the heels of passage of federal legislation establishing pilot mental health courts, local and state officials should implement pilot programs in Ohio and monitor their effectiveness.
- C.** ODMH and local leaders should increase their commitment to local diversion and linkage programs by expanding existing diversion and linkage efforts, and securing funds to implement programs where none exist.
- D.** ODMH and the Department of Rehabilitation and Correction should work cooperatively to enhance the planning process for the release of offenders with a mental illness.
- E.** ODMH should work with boards and agencies to increase the housing and treatment service capacity and responsiveness to offenders with mental illness who are transitioning from prison to the community.

Adults with Intensive Service Needs

Some individuals with mental illness are so severely ill that despite best practices and best efforts they are not able to live safely in their community. These people are often neglected, or their existence denied. Often, the only way a person can be considered appropriate for long-term hospitalization is if he or she is a forensic patient. For consumers too ill to play a meaningful role in their treatment (i.e., those who lack decision making ability), there is a role for advanced directives, outpatient commitment and limited medical guardianship on either a short or long term basis. How these directives are handled is crucial. There need to be safeguards to ensure advanced directives are followed.

System Design Finding: *There is a service gap between involuntary hospitalization and community-based residential treatment for those people with a serious mental illness and intensive treatment needs.*



Recommendation:

- A.** ODMH and local system partners should meet the need for appropriately staffed residential facilities with structured programs to serve people with severe, persistent and disabling mental illness.

CHANGING LIVES

A 31 year-old homeless man is seen by the mental health counselor in the county jail, where he is noted to be acting strangely. This is Robert's 14th incarceration during the past year – once for felony drug possession, the remainder for misdemeanor charges like criminal trespassing.

Robert has never been violent and is well known to the local mental health system, where he has been in and out of treatment for 15 years. He has been diagnosed as having paranoid schizophrenia, polysubstance abuse (mostly alcohol and cocaine) and borderline mental retardation. In addition, he is a diabetic and has high blood pressure.

This most recent incarceration was precipitated by a visit to the community mental health center at a time in which he was clearly high on cocaine. The center refused to treat him and immediately referred him to the nearby public drug treatment program for residential treatment. When evaluated by the center's staff, Robert was found to be actively hallucinating and delusional, fearful that others wished to kill him. Therefore, he was asked to return to the mental health center.

Unfortunately, Robert did not keep his appointment and was arrested by police the following day after a disturbance at a local restaurant. The police contacted the community mental health center and

were told that since the patient failed to keep his appointment, his case was closed. Moreover, he would have to make a new appointment for assessment, which could be scheduled, at the earliest, in six weeks.

The police were concerned about the potential for self-harm and therefore took Robert to the emergency ward of the local hospital. This evaluation confirmed his psychotic symptoms but the emergency physician judged the man's greatest problem to be cocaine abuse and recommended that the police place him in jail. Being worried about Robert's well-being, but not knowing what to do to help him, the police filed criminal trespassing charges and incarcerated him once again.

LESSON: Among the problems common to many community mental health systems is the absence of integrated treatment programs that can care for those with both severe mental illness and substance abuse. Also, local systems often lack treatment programs that care for those with severe mental illness and mental retardation. There is typically poor communication between mental health and substance abuse programs, and there is an unfortunate reliance on the criminal justice system to care for patients with complex clinical needs.

Co-occurring disorders. Other people with multi-system needs often fall through the holes in the mental health safety net. According to the Surgeon General's Report, three percent of the U.S. population in a given year experiences co-occurring mental illness and substance abuse disorders. As many as half of all people with a serious mental illness may suffer from co-morbid substance abuse (Surgeon General's Report). Co-occurring disorders are common for public mental health providers, and treating both conditions is essential but difficult.

This issue takes on greater importance for the 43 local boards in Ohio that share responsibility for coordinating mental health and addiction services. In 1989, most community mental health boards had to assume responsibility for the treatment of addiction to alcohol or other drugs. But public funding for substance abuse treatment has not been adequate, so the mental health system may assume some of the fiscal responsibility for people with co-occurring disorders.

For people with co-occurring mental illness and mental retardation, coordination between two separate systems, with two distinct missions, is needed. The responsible state agencies (ODMH and ODMR/DD) have initiated a statewide project to improve services to this population. This effort should continue and expand.

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System Design Finding: *Treating people with co-occurring mental illness and substance abuse disorders is difficult, and requires careful coordination of mental health and recovery services.*



Recommendation:

- A.** The mental health and recovery services systems at the state and local levels should work together to provide fully integrated services to people with co-occurring disorders.

System Design Issues Impacting Older Adults

A comprehensive public mental health service delivery system for older adults does not exist in Ohio. The problem cuts across all levels of the system. ODMH has few dedicated staff resources and programs that focus on older adults. At the local mental health system level, staff and programs in community mental health systems often lack the specialized training or focus to meet the individual needs of older adults. And it continues throughout a fractured service delivery system that includes the mental health system, general health care, senior centers and nursing facilities, public aging networks, and other entities.



At a time when resources are scarce and access demands are great, older Ohioans have clearly not been the public mental health system's number-one priority. But the number of older adults in Ohio is expanding at the same time research and information are demonstrating the need for services and interventions tailored to meet the needs of aging Ohioans. Public mental health must play a leadership role in developing a more collaborative service delivery system for older adults.

Older adults are different from younger adults in how they access and receive mental health services. Older adults with a severe and persistent mental disorder are the most frequent users of long-term care in community or institutional settings. Nationally, 89 percent of institutionalized older persons with severe mental illness now live in nursing homes, not mental health facilities. But the majority of older adults with severe mental illness presently live in the community with services supplied by a complex array of sources (Surgeon's General Report).

The public mental health system's response to the unique access and service needs of older adults in local communities must include a focus on evidence-based practices. It requires the system to provide services where and when they are convenient and acceptable to older adults. The mental health system must play a more prominent role in bridging gaps, and linking with other systems (i.e., the Department of Aging and Area Agencies on Aging) and entities (i.e. faith-based organizations, nursing homes and other long-term care facilities, elder-care facilities, and primary care physicians) that serve older adults.

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System Design Finding: *Public mental health must play a more active role in developing and coordinating a delivery system for mental health services that is responsive to the unique needs of older adults.*

Recommendations:

- A.** ODMH should create a leadership capacity to develop and coordinate mental health services to older adults.
- B.** ODMH, in conjunction with community mental health systems, should evaluate ways to develop and implement accessible services for older adults. These methods must include establishing collaborative relationships with other public and private systems that provide health services to older adults.

Funding Support

V

From fiscal years 1990 through 2001, state funding for public mental health decreased relative to inflation. Private-sector support for mental health also decreased. During the same period of time, the demand for mental health services provided through the public mental health system was rising, and it has continued to rise. Throughout the 1990s, Ohio's response to unmet need could be addressed through the reallocation of resources from state hospitals, increased billings to Medicaid, and increased local levies. Each of these sources has dried up (and Medicaid match requirements are now straining many local systems), but the challenges and responsibility for the public mental health system remain. Ohio strongly supports home rule, but not without some costs. The current level of resources required to maintain 50 boards and nearly 500 agencies creates an additional strain on the system.

As a result, Ohio faces a mental health funding crisis that threatens the public mental health system's ability to meet basic access and quality demands that are essential to its mission, vision, and values.

Previous chapters have focused on suggestions for meeting access and quality challenges by improving efficiency at the state, local and federal levels, by increasing federal and private sector support for mental health, and by promoting the use of clinical practices that meet the needs of the public. But at the core of addressing this crisis must be a commitment to increasing the level of funding for Ohio's

Overall Funding Support Finding: *Ohio faces a mental health funding crisis that threatens the public mental health system's ability to meet basic access and quality demands.*

public mental health system. Ohio must also address Medicaid-related fiscal pressures that are barriers to efficiency and a drain on local system resources.

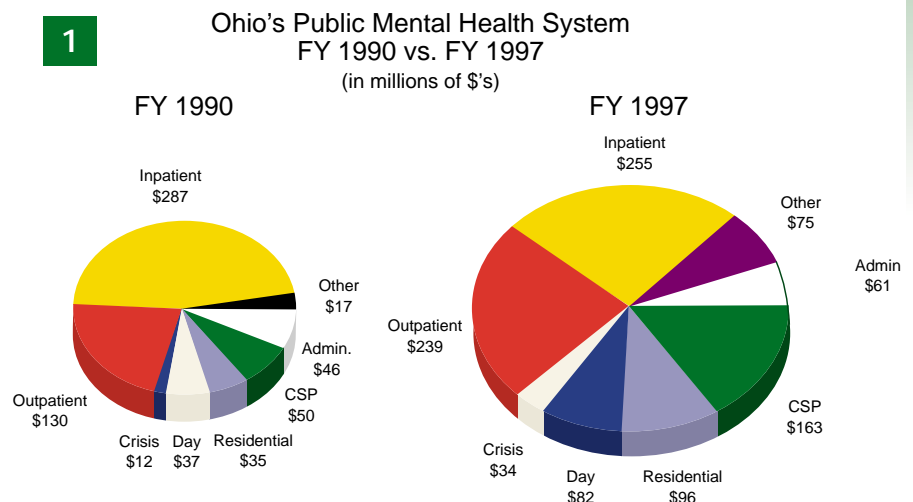
Trends in Funding for Mental Health Services in Ohio

The following trend data illustrates the need for new and/or expanded funding resources for Ohio's mental health system:

1. Implementation of the Mental Health Act has changed funding priorities and redirected state hospital resources to community care, and fundamentally changed the mix of community services.

For example:

- Savings from ODMH hospital downsizing and restructuring have led to increased funding for community services, and the mix of community services now emphasizes community support and other services for SED/SMD persons. (Graphs 1 and 2)



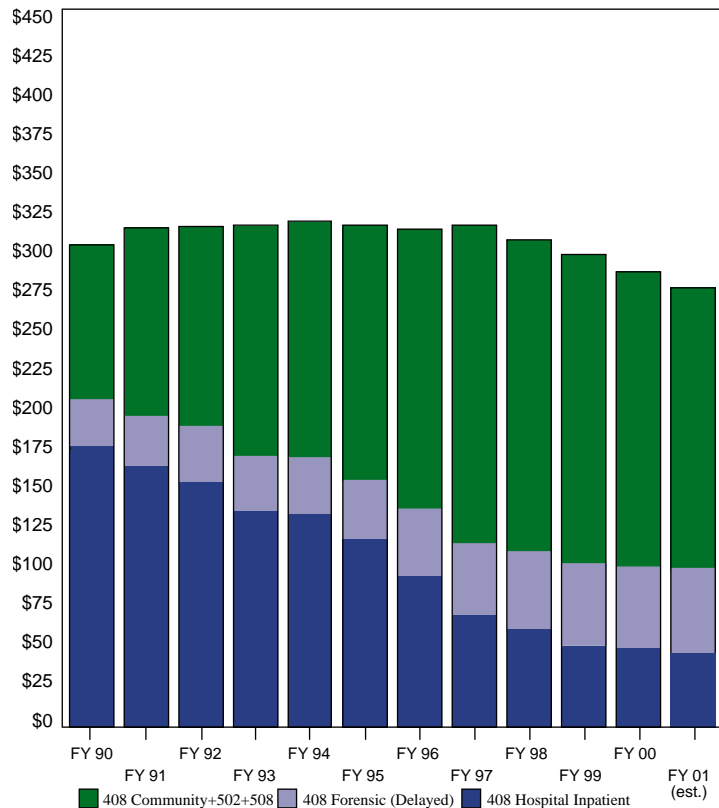
- Ohio's public system has achieved efficiencies not seen in other states. But the cost savings from these efficiencies have been realized, and additional revenue from additional hospital downsizing is not forecasted. (Graph 3)

2. Funding for public mental health has not kept pace with inflation (or with funding for other agencies and programs).

- Total state GRF funding has declined relative to inflation over the past decade. (Graph 2)
- Local levies and federal support have leveled off. (Graph 4 and 5)
- The data below reflects State GRF budget growth from FY 1990 to FY 2001 (adjusted) for the following areas:
 - Overall State Budget – 28 percent increase
 - Education – 53 percent increase
 - Health care (Medicaid) – 51 percent increase
 - Institutional agencies
 - Corrections – 114 percent increase
 - Youth services – 65 percent increase
 - **Mental Health – 1.5 percent decrease**
 - MR/DD – 1.9 percent decrease

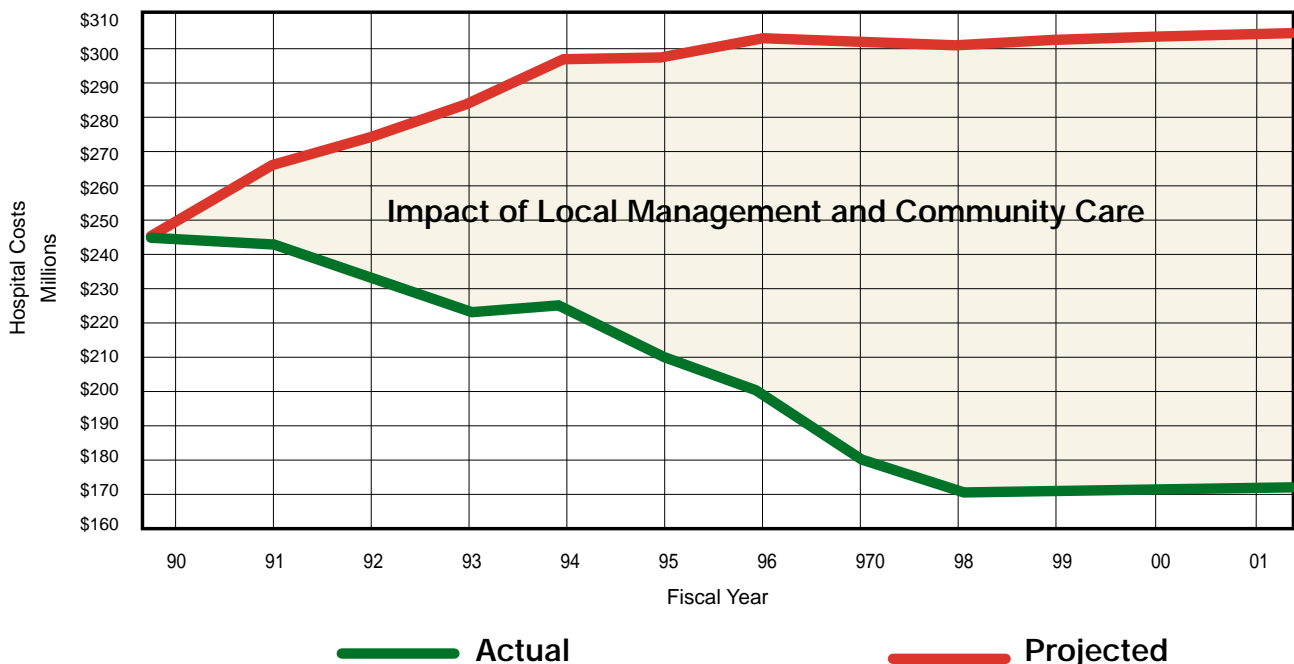
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Department of Mental Health
Major GRF Accounts (In FY 90 dollars—assuming 3% per year inflation)
Sources: o\data\lotus\2000-01\MAJACCT2.123



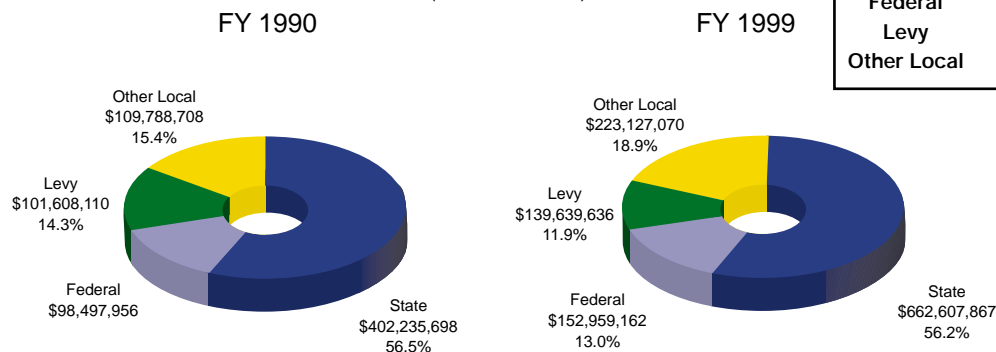
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Actual vs. Projected Hospital Costs • Department of Mental Health



4

Ohio's Public Mental Health System Financing FY 1990 vs. FY 1999 (in millions of \$'s)



5

State-wide Levy Analysis

Year	# of Levies on the Ballot	New		Renewal		Replacements	
		Pass	Fail	Pass	Fail	Pass	Fail
1988	23	9	8	5	1	0	0
1989	16	7	4	5	0	0	0
1990	12	0	6	5	0	0	1
1991	21	1	8	8	0	2	2
1992	12	1	5	3	0	2	1
1993	12	0	5	5	1	1	0
1994	22	1	10	9	1	0	1
1995	23	0	4	10	2	6	1
1996	8	0	4	2	0	1	1
1997	6	0	0	2	0	1	3
1998	20	0	4	6	1	8	1
1999	3	0	1	1	0	0	1
2000	13	0	5	3	0	3	2
Total	191	19	64	64	6	24	14

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Mental Health Funding Comparison 1996-1997

Mental Health

	Total	Fed/State	Local/Levy
Ohio	\$93	\$60	\$33
Michigan	\$107	\$95	\$12
USA	\$110	\$110	—*

* Local funding is very limited in most states.

Sources: Lutterman, Braddock, Mark

3. A comparison of state mental health financing trends across the nation shows that funding for Ohio's system is lagging behind other states. (Graph 6)

- Ohio spending on inpatient and residential services is much less than state mental health authority averages nationwide (\$21 vs. \$35). Ohio spends less on costly services.
- ODMH revenues per capita (FY '97) are less than the national average for state mental health authorities (\$52 vs. \$61).
- On average, inflation-adjusted revenues for state mental health authorities nationwide declined 6.5 percent from FY '90 through FY '97. Revenues for ODMH declined 1.5 percent in the same period.
- Mental health is not faring well in state budgets, generally. However, while spending for mental health as a percentage of all state spending is declining nationwide, the situation in Ohio is comparatively dire.

Collectively, the preceding data reveal the fiscal crunch in mental health. Demand is increasing. Expenditure pressures and trends continue. Revenues are now flat, hospital closures and reengineering are complete, and Medicaid funding has become a drain and not an asset.

Funding Support Finding: *Ohio faces a mental health funding crisis that threatens access to important mental health services and interventions.*

Recommendations:

- A.** Governor Taft and the Ohio General Assembly should make a strong commitment to improving access for mental health services and increase state funding for mental health.
- B.** The mental health system should commit to balancing increased administrative and fiscal efficiencies with a focus on quality at the state, local and federal levels.

Medicaid Strain on Local System Resources

Over the past decade, community mental health Medicaid expenditures in Ohio have grown exponentially, from approximately \$60 million in FY 1990 to \$225 million in FY 1998. At first glance, this appears to be a fiscal windfall for Ohio. But federal Medicaid funds come attached to regulations that are often barriers to efficiency and quality. And because Medicaid is a federal entitlement, meeting the demand for Medicaid services often comes at the expense of more appropriate “non-Medicaid” services. In some communities, Medicaid match requirements are leading local systems into deficit spending.

This growth of Medicaid funding in Ohio is attributed to two primary factors. First, the implementation of the Mental Health Act increased the need for and availability of resources to serve adults returning to the community as well as those already living there who are underinsured. Second, Ohio’s broad Medicaid coverage for mental health services permitted the dollars transferred to local communities through the implementation of the Mental Health Act to be used as state and local matching funds to draw down the 60 percent federal Medicaid reimbursement.

Medicaid has been an invaluable resource in the development of Ohio’s community system. However, in more recent years, a number of local boards have experienced mounting pressures of Medicaid match demands. These are particularly acute in the face of slowed state and local revenue growth following the completion of state hospital downsizing. Increasingly, local systems are in need of more effective tools to manage the costs of providing Medicaid services.

There are several other Medicaid-related fiscal pressures confronting individual boards. Because Medicaid is an entitlement program, any minimally qualified provider must be given a Medicaid agreement, even if there are already sufficient providers to meet the demand for

Funding Support Finding: *The demand for Medicaid contracts and services is becoming an increasing drain on mental health resources. It is a barrier to efficiency and quality. The demand is reducing access and availability of non-Medicaid services.*

Recommendations:

- A.** The Taft Administration should pursue a Medicaid waiver for community mental health services.
- B.** ODMH should develop and implement alternative strategies to make Medicaid more flexible in lieu of and/or to augment a Medicaid waiver.

services. Also, the current system has no limitations on amount, duration, and scope of covered services. The current cost-based rate structure does nothing to encourage efficiency. In fact, to some extent, it provides disincentives to efficiency.

Because Medicaid functions as a medical insurance model in which services must be of a “medical nature,” local systems have experienced difficulty in aligning it as a resource that supports services that are essential to promoting recovery. Medicaid will not pay for many supportive services, such as residential and employment services, that are important to recovery. It also does not work well in promoting collaboration. As an example, Medicaid is a poor funding source for school-based programs because of the strict federal requirements to isolate medical programs from educational programs.

The mental health system has collaborated on the development of a series of controls that can be established in a fee-for-service Medicaid program, as well as additional controls that would require a waiver of certain federal Medicaid requirements. A set of waiver controls is seen as the only viable long-term solution because it would promote the type of flexibility needed in Ohio’s locally managed system. Redeveloping a waiver program likely will take several years, especially since the state Medicaid agency is saddled with problems in other areas within the state Medicaid program.

Over the next two years several board areas, primarily those with higher than average populations of Medicaid-eligible persons and lower-than-average local resources, will likely experience potentially crippling match problems. Attention is being given to developing a set of non-waiver controls to assist in moderating expenditure growth, but such controls alone may not be successful in solving the problems.

Conclusion



Next Steps: Building our Future Together

This report was developed with extensive input and cooperation from a diverse group of interested parties and partners. A similar collaborative commitment will be required to meet the challenges that now face Ohio's public mental health system. It is the Commission's hope that interested parties and the general public will embrace and advance this report and the findings and recommendations contained herein.

This report reflects the best efforts of this Commission to lay the foundation for addressing the critical issues that are facing the public mental health system. Surely, much more must be done to bring about resolution of the issues highlighted in this report and other issues that might remain outstanding. To that end, the Commission concludes with these final recommendations:

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Recommendations:

- A.** ODMH must develop and implement an action plan for the recommendations contained in this report. The action plan should include and make explicit the roles of the Planning Council and the System Linkages Group in executing the recommendations in this report.
- B.** The Commission must be charged with meeting periodically over the next 18 months to review the action plan and oversee the implementation of the recommendations in this report.

To give feedback on this report, please write the Ohio Mental Health Commission c/o ODMH at 30 East Broad St., 8th Floor, Columbus, Ohio 43215. You can also give feedback on this report and follow/comment on the action plan at the ODMH Web site www.mh.state.oh.us. We welcome your input.

Summary of Commission Meetings

December 8, 1999

- Introduction of Commission members and the Commission Chair
- Commission welcome and charge by ODMH Director Hogan
- Discussion of communications strategy
- Preview of Surgeon General's Report

January 7, 2000

- Examination of the Surgeon General's Report
- Review of the forums and feedback from the forums
- Structuring of the Commission's work

February 9, 2000

- Discussion of the Surgeon General's Report with Howard Goldman, M.D., Ph.D., Senior Scientific Editor of the Report
- Development of a matrix for the Commission's report, including areas of attention, age groups and filters
- Discussion about breaking into subgroups to address issues specific to children and youth, adults and older adults (and areas of attention within these groups)

March 1, 2000

- Finalization of filters and areas of attention
- Discussion and recommendations for future presentations
- Discussion of funding and fiscal issues and challenges with Dalon Myricks, ODMH Chief of Fiscal Administration and Rick Tully, ODMH Chief of Fiscal Policy

April 5, 2000

- Discussion of issues specific to children and youth with ODMH Director Hogan and Kim Kehl, ODMH Chief of Children's Services
- Preliminary discussion of findings and recommendations for children and youth
- Mapping of agenda for the remainder of the year

May 3, 2000

- Finalization of discussion on issues specific to children and youth, and formulation of draft findings and recommendations for this population
- Discussion on coordinating with other child serving systems with representatives of the Ohio Departments of Alcohol and Drug Addiction Services, Youth Services, Education, and Job and Family Services
- Formation of the Adult Subcommittee

June 7, 2000

- Discussion of the upcoming presentation at the Millennium Conference
- Status report of Communication, Child and Youth and Adult Subcommittees
- Discussion of adult issues—funding, systems of care, special population needs, access, etc.
- Discussion of challenges for serving adults with ODMH Director Hogan

July 5, 2000

- Promoting best clinical and administrative practices and a discussion with ODMH Medical Director Dale Svendsen, M.D.
- Employment and housing, especially for people with severe and persistent mental illness
- Discussion of findings and recommendations for adults
- Discussion of adult-specific issues and coordinating with other public systems that serve adults with representatives of Ohio Departments of Alcohol and Drug Addiction Services, Job and Family Services, Mental Retardation/Developmental Disabilities, Rehabilitation and Correction, the Rehabilitation Services Commission, and Center of Vocational Alternatives

September 6, 2000

- Development of the final report format and matrix
- Discussion of Ohio Access issues relating to the recent Supreme Court Olmstead decision.
- Presentation of the Coalition for Healthy Communities funding proposal by Linda Siefkas and Stacey Smith
- Preparation for October discussion on issues specific to the elderly and development of Older Adult Subcommittee

October 4, 2000

- Discussion of cultural competence
- Discussion of issues specific to older adults with representatives of the Ohio Department of Aging, Benjamin Rose Institute, North Central Mental Health Center, and Veteran's Administration
- Development of preliminary findings and recommendations for older adults

November 1, 2000

- Discussion of cultural competence and development of findings and recommendations
- Reports from Children and Youth, Adult and Older Adult Subcommittees on areas of attention and other findings and recommendations
- Final review and revision of subcommittee reports
- Finalizing draft of findings and recommendations

Glossary

408- A budget line item implementing the fiscal aspects of the Mental Health Act of 1988. Funds in this line item go from ODMH to local mental health boards to pay for inpatient services as well as community services for those with severe mental illnesses.

419- A budget line item that provides funding for community medication subsidies.

502- A budget line item that provides funding to CMH and ADAMHS Boards to provide local mental health services.

508- State budget line item that provides funding to CMH and ADAMHS Boards to provide local mental health services to severely disabled adults, adolescents and children.

ACCESS- The assurance that consumers are aware of the local array of mental health services and are afforded the opportunity to receive needed services and supports in a timely manner.

ADAMHS (Alcohol, Drug Addiction and Mental Health Services)/ CMH (Community Mental Health) Board- One of the 50 community mental health boards established by Ohio Revised Code, Chapter 340.03 to provide local planning, management and funding of mental health services in Ohio at the local level.

ADRP- Average daily resident population (measurement of utilization of state hospitals).

ADULT CARE FACILITY- Facilities that are licensed by the Ohio Department of Health that provide room, board and personal assistance to individuals in need across the state of Ohio. Of approximately 800 ACFs licensed in Ohio, about 500 provide personal care services to persons recovering from mental illness.

ADVANCE DIRECTIVES- A legal means (document) by which a person can specify his/her choice about how he/she will be treated in the event that his/her illness renders him/her incapable of exercising choice.

ADVOCACY- Activities in support of individuals with mental illness, including rights protection, legal and services assistance, and system or policy changes.

AGEISM- Myths and misperceptions about older people.

ALTERNATIVE EDUCATION INITIATIVE- A statewide interagency effort to improve school success for high-risk children and youth, including removing barriers to student learning.

BHO- Behavioral Healthcare Organization (formerly known as state hospitals.)

BLOCK GRANT- Block grants include a broad range of related activities with less precise purposes, are subject to relatively few regulations and are provided in a lump sum with some approval required for expenditure.

BUY-IN OPTIONS- This is a federal Medicaid reform recently enacted by Congress that allows states to modify Medicaid eligibility rules which permits disable persons returning to work to secure extended Medicaid coverage, but also requires such persons to contribute toward such coverage, according to rules established by the State. Ohio has not taken action on this measure yet.

CASE MANAGEMENT- Services that link the individual with appropriate service providers, monitors progress and provides advocacy services.

CENTER FOR INNOVATIVE PRACTICES- One of ODMH's Centers of Excellence focused on assisting communities in implementing Multi-Systemic Therapy.

CENTERS OF EXCELLENCE- Cooperative ventures between the Ohio Department of Mental Health, the academic community in Ohio and the community mental health system to implement best practices and evidenced based practices into the community mental health system in Ohio.

CLINICAL BEST PRACTICE- Consumer-focused, evidence-based interventions and services that have demonstrated good outcomes for consumers.

COEDI- Children's Ohio Eligibility Determination Instrument. This refers to a test to determine the eligibility of persons for state and county MR/DD services.

COMMISSION ON MENTAL HEALTH SERVICES- A group of 18 individuals, representing diverse perspectives on the mental health system, who were appointed by Director Michael Hogan to make findings and recommendations for change to the vision, mission, values and priorities of mental health care in Ohio.

COMMUNITIES THAT CARE- A risk and protection-focused prevention model based on decades of research on the causes and correlates of juvenile problem behavior.

COMPETENCE- Implies having the capacity to function effectively. Also a legal term (i.e., competency to stand trial).

CONSUMER- Person who has been or is receiving mental health services and/or supports.

CO-OCCURRING DISORDERS- The simultaneous presence of two or more disorders (e.g., substance abuse and mental illness).

CULTURAL COMPETENCE- A set of congruent behaviors, attitudes and policies that integrate within a system, agency or among professionals, and enables that system, agency or professional to work effectively in cross-cultural situations.

CULTURE- The integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious, age or social groups and demographics.

DE-INSTITUTIONALIZATION- Preventing unnecessary retention in and admission to public hospitals through the timely discharge of admitted patients and the diversion of potential candidates for admission to other treatment services and facilities. With the passage of the Community Mental Health Centers Act of 1963, deinstitutionalization of mentally disabled persons became a national mental health policy.

DEVOLVED- A practice of moving the responsibilities down to more local levels of government.

DIVERSION PROGRAMS- Programs designed to screen people out of the criminal justice system and into appropriate mental health/drug/alcohol services before the person becomes incarcerated.

DUNN v. VOINOVICH- This lawsuit grew out of the Lucasville prison riots and was settled out of court. It restructured the way mental health services are delivered within state prisons in the State of Ohio.

EARLY CHILDHOOD MENTAL HEALTH INITIATIVE- A statewide initiative to add quality to Ohio's existing early childhood programs targeting children from birth through age five, such as Early Start, Head Start and child care, through mental health training and consultation services; some direct mental health services are also provided, as well as work with families with young children.

EARLY INTERVENTION COLLABORATIVE- State and local workgroups focused on improving services for children with developmental delays or disabilities.

EARLY START ADVISORY COUNCIL- A state interagency workgroup focused on expanding and fine-tuning Ohio's Early Start Program which targets families with children under age three.

EMERGING BEST PRACTICES- Defines the current best practices that consumers, clinicians and community supports use to facilitate the recovery process. New best practices are continuing to emerge.

ERISA (EMPLOYEE RETIREMENT INCOME SECURITY ACT) - Refers to federal laws which govern employer based retirement, health care coverage, and other employee benefit plans. ERISA supercedes almost all state laws that affect employee benefits.

FALL FORUMS- A series of 9 public meetings held between October 12, 1999 and December 7, 1999 co-sponsored by ODMH and community partners throughout the state. Input was solicited from the public on the Mental Health System's Vision, Mission, Values and Priorities as well as specific topics. (Mental Health and Schools, Community Support Services Facilitating Recovery, Housing and Employment, Criminal Justice, Cultural Competence, Children and Adolescents, Best Practices and Children and Families).

FAMILY AND CHILDREN FIRST CABINET COUNCIL - Defined in statute as the Directors of the Departments of Alcohol and Drug Addiction Services, Budget and Management, Education, Health, Job and Family Services, Mental Health, Mental Retardation and Developmental Disabilities, and Youth Services. The Governor or his designee chairs the Council.

FAMILY STABILITY INCENTIVE FUND- A performance based, multi agency program designed to reduce the number of children and youth placed out of their homes. Services include but are not limited to financial assistance, family support, crisis counseling and respite care. Grant money is received only after placement reduction goals are achieved quarterly and annually.

FAMILY SUPPORT- Persons identified by the consumer as either family members or significant others who provide the necessary support for recovery.

FEE FOR SERVICE- Refers to the predominant method of payment for healthcare in which a payor pays a provider for treatment provided upon submission of a valid claim, in accordance with agreed upon business rules. This payment method is distinguished from those used in some managed care plans, such as capitation or case rate.

FIDELITY- Research-established criteria used to measure a program's "fit" with a "best practice" or an evidenced-based program, e.g., MST, PACT, etc.

FORENSIC- A term used to describe a person with mental illness involved in the criminal justice system, including persons found Incompetent to Stand Trial, Not Guilty by Reason of Insanity,

persons in jails and prisons with mental illness and people with a mental illness referred to the mental health system by the criminal court for evaluation and treatment.

GENERAL REVENUE FUND- State appropriations.

GRADUATE PREPARED PERSON - Person who has attended and graduated from a college/university accredited program to perform or provide services requiring specialized knowledge and skills. An example would be a person practicing in the mental health field who has at least a Master's degree or higher in a related field.

HCFA- Health Care Financing Administration.

HOME AND COMMUNITY BASED SERVICES (HCBS)- Refers to a federal waiver of Medicaid requirements which permits payment for services not ordinarily covered by Medicaid and also permits individuals to receive income and accumulate resources at levels higher than ordinarily permitted for individuals previously receiving institutional services paid by Medicaid. Most of the current HCBS waiver programs are for MRDD persons. This program has very limited applicability for persons with mental illness because Medicaid does not pay for institutional services for most adults (see IMD waiver).

HUD SECTION 8 VOUCHERS- The section 8 rental voucher and rental certificate programs are the federal government's major programs for assisting very low-income families, the elderly, and the disabled to rent decent, safe and sanitary housing in the private market. Since the rental assistance is provided on behalf of the family or individual, participants are able to find and lease privately owned housing, including single family homes, townhouses and apartments. The participant is free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects.

ICF (Intermediate Care Facility)- An institution licensed under state law to provide health related care and services to individuals who do not require the degree of care or treatment that a hospital or skilled nursing facility provides.

IMD WAIVER- Refers to the waiver of federal requirements granted by the U.S. Secretary of Health and Human Services, permissible only in federal demonstration waivers, which allows Medicaid to pay for services for persons between the ages of 22 and 64 who are receiving treatment in private or public free-standing psychiatric hospitals. Current Medicaid law prohibits payment for these services.

INVOLUNTARY CIVIL COMMITMENT- Standards that permit a state to hospitalize persons who are mentally ill against their will because they pose a danger to self or others.

INVOLUNTARY OUTPATIENT COMMITMENT- Enables courts to compel outpatient treatment for those with mental illness who need treatment but who are incapable of deciding voluntarily to seek it, and who comply with treatment orders.

ICO STUDY- The Longitudinal Study of Mental Health Services and Consumer Outcomes in a Changing System is a continuation and expansion of the Services in Systems Study, which was implemented to test a model which included characteristics of consumers, service packages and outcomes. This longitudinal study contains two parts. The first part focuses on the effects of system changes on the yearly service patterns of individuals with severe mental illness. The second part focuses on consumers' individual experiences within the mental health system and includes five waves of measurement.

Glossary

LINKAGE PROGRAMS- Programs designed to link individuals being released from the criminal justice system after completing their sentence, to ensure appropriate follow-up services.

MACSIS (Multi-Agency Community Services Information System)- An Ohio automated payment and management information system for mental health services.

MANAGED CARE- A health care delivery system that attempts to keep costs down by managing the care to eliminate unnecessary treatment and reduce expensive hospital care. The most familiar models are health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

MEDICAID MATCH- The federal government requires that the state/local government match the federal government funds for Medicaid reimbursement services. In Ohio, this is approximately 60 percent (federal)/40 percent (state/local) match.

MEDICAID DISINCENTIVES- This refers to eligibility rules inherent in the Medicaid and Social Security programs which function as disincentives for disabled people to return to work. A number of recent legislative reform provisions now permit these disincentives to be overcome.

MEDICAID SPEND DOWN- This refers to a set of Medicaid eligibility rules which permits disabled individuals whose income exceeds Ohio's need standard to become eligible for Medicaid by showing proof of expenditures, usually on a monthly basis, for medical services.

MEDICALLY NECESSARY- Refers to criteria established by public and private health insurers to ensure that medical treatment is necessary and appropriate for the condition or disorder for which treatment is provided. Review methods employed by insurers include retrospective, concurrent, and pretreatment reviews.

MEDSTAT STUDY- A study of health care expenditures performed by MEDSTAT, a health information company that provides decision support systems, market intelligence, databases, and research for managing the purchase, administration, and delivery of health services and benefits.

MENTAL DISORDERS- Health conditions that are characterized by alterations in thinking, mood or behavior (or some combination thereof), associated with distress and/or impaired functioning.

MENTAL HEALTH- A state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until death, mental health is the springboard of thinking and communication skills, learning and emotional growth, resilience and self-esteem.

MENTAL HEALTH ACT OF 1988- Changed funding allocations, mandated each ADAMHS Board establish a community support system, provided that persons civilly committed would be committed to a Board and not a hospital, established a risk fund and clarified the responsibilities of the ADAMHS Boards as the single authority for the mental health system in each community including the provisions for the Community Mental Health Plan.

MENTAL HEALTH CORPORATIONS OF AMERICA- National organization that has a nationwide mental health data base, and is used by some boards and their providers to compare their consumer satisfaction data to this data base.

MENTAL HEALTH COURTS- Courts that provide continuing judicial supervision of non-violent offenders with mental illness or co-occurring disorder. Provides coordinated delivery of services,

voluntary outpatient or inpatient mental health treatment with the possibility of dismissal of charges or reduced sentencing upon completion of treatment, centralized case management and continuing supervision of a treatment plan. The Congress recently passed a bill to provide grants to states, courts and local governments to establish mental health courts.

MENTAL HEALTH SERVICES TO JUVENILE OFFENDERS PROJECT- A pilot project implemented in three sites to create comprehensive systems of care for juvenile offenders with mental illnesses.

MENTAL ILLNESS- The term that collectively refers to all mental disorders.

MOST IN NEED- The most severely mentally disabled adults.

MULTI-SYSTEMIC THERAPY (MST)- An intensive family and community-based treatment that addresses the multiple determinants of serious anti-social behavior in juvenile offenders. MST addresses the multiple factors known to be related to delinquency across the key settings or systems, within which youths are embedded (e.g., family, peers, schools, neighborhoods). MST strives to promote behavior change in the youth's natural environment, using the strengths of each system to facilitate the change.

NAMI-OHIO (National Alliance for the Mentally Ill of Ohio)- An organization dedicated to self-help and family advocacy and improving the lives of those with severe mental illnesses. The organization was built with four cornerstones in mind, support, education, advocacy and research.

NATIONAL SUICIDE PREVENTION STRATEGY- A strategy that includes 15 key recommendations to assist national, state and local entities in shaping policies and allocating resources to programs.

OAMH (Ohio Advocates for Mental Health)- A statewide advocacy organization whose mission is to educate society about mental illness and the needs and goals of those affected by mental illness. OAMH also advocates for those with mental illness.

OCBHP (Ohio Council of Behavioral Health Professionals)- An organization whose vision is to improve the health status of Ohio's communities. They also promote effective and adequate behavioral health care through their members (providers of mental health and addiction services).

OHIO ACCESS INITIATIVE- A process initiated by Governor Taft to provide a comprehensive review of Ohio's services and support systems for people with disabilities, and to make recommendations for improving these services.

OHIO MENTAL HEALTH CONSUMER OUTCOMES INITIATIVE - The effort to develop a standard, statewide approach to measuring consumer outcomes in Ohio's publicly supported mental health system. The Outcomes Task Force, convened in 1996 by Director Michael Hogan, began this effort. Further design and testing was conducted by the Consumer Outcomes Implementation Pilot Group and most boards are now in some stage of implementation.

OHIO WORKS FIRST- A program administered by the Ohio Department of Jobs and Family Services(ODJFS) which provides cash assistance and job-finding services and training to needy families.

OLMSTEAD v. LC- A recent U.S. Supreme Court decision that found that people with a disability have a right to services in the least restrictive environment.

OUTPATIENT- An individual (patient) who receives health care services (such as surgery) on an outpatient basis, meaning they do not stay overnight in a hospital or inpatient facility. Many insurance companies have identified a list of tests and procedures (including surgery) that will not be covered unless they are performed on an outpatient basis. The term outpatient is also used synonymously with ambulatory to describe health care facilities where procedures are performed.

PARITY- Refers to a series of initiatives at the national and state levels to achieve a greater recognition of the efficacy of and equitable coverage for treatment for mental disorders compared to physical illnesses by private and public health insurers.

PATHWAYS PROGRAM- A program jointly funded by local community systems, the Ohio Rehabilitation Services Commission and the Federal Government to provide streamlined services for particular disability groups.

PCSA (Public Children Services Agency)- County agencies charged with preventing child abuse and neglect in Ohio.

PEER SUPPORT- Services offered by mental health consumers, persons with addictions or others to provide support to one another. Peer support services can include drop-in centers, warm lines, peer respite care or support groups.

PROGRAM OF ASSERTIVE COMMUNITY TREATMENT (PACT)- A highly structured, multidisciplinary program of intensive treatment, rehabilitation and support services to clients in their homes, on the job and in social settings.

PSYCHOSOCIAL REHABILITATION- Traditional mental health services, as well as a variety of social learning, vocational and community living programs.

PUBLIC MENTAL HEALTH SYSTEM- Refers to the network (ODMH, CMH/ADAMHS Boards, and mental health service agencies funded by CMH/ADAMHS Boards) of administrative and service organizations responsible for the provision of publically funded services to persons who require mental health treatment.

QUALITY SERVICE- Convenient, comprehensive services that meet individual needs and are delivered in a clinical and culturally competent manner.

SCHIZOPHRENIA PATIENT OUTCOMES RESEARCH TEAM (PORT STUDY)- A study funded by the Agency for Health Care Policy and Research and the National Institute for Mental Health to develop and disseminate recommendations for the treatment of schizophrenia based upon existing scientific evidence.

SED (Severely Emotionally Disturbed)- A designation for those individuals under 18 years of age who have serious emotional disturbances and are at the greatest risk for needing services. The SED designation has been made using three components: diagnosis, duration of impairment and level of functioning.

SMD (Severely Mentally Disabled)- A designation for those adults with severe and persistent mental illnesses who are at the greatest risk for needing services. The SMD designation has been made using four components: the receipt of SSI/SSDI for a mental impairment, diagnosis, duration of impairment and level of functioning.

SERIOUSLY OR CHRONICALLY DISABLED- Term used to describe persons who suffer certain mental or emotional disorders that erode or prevent the development of their functional capacities in relation to such primary aspects of daily life as personal hygiene and self-care, self-direction, interpersonal relationships, social

transactions, learning and recreational activities.

STATE MENTAL HEALTH AUTHORITY- Refers to the single state agency designated by each state's Governor to be the state entity responsible for the administration of publicly funded mental health programs in the state. In Ohio, this entity is ODMH.

STIGMA- Stereotypes associated with mental illness that hinder and/or negatively impact the recovery process.

SURGEON GENERAL'S CALL TO ACTION TO PREVENT SUICIDE- A blueprint to save lives with a focus on awareness, intervention and research. It is contained in a report by the same name and was released on July 28, 1999.

SURGEON GENERAL'S REPORT- A review of research on mental disorders from U.S. Surgeon General David Satcher. This first U.S. Surgeon General's report titled, *Mental Health: A Report of the Surgeon General* published in December 1999, captures progress made in the last 10 years in understanding and treating mental illness and reducing stigma. In addition, the report examines such things as treatment, what people go through when seeking care, and the care system. A copy of the Executive Summary is available by calling 1-877-964-3258.

RECOVERY- A personal process of overcoming the negative impact of a psychiatric disability despite its continued presence.

RELAPSE PREVENTION PLAN- A shared understanding between the consumer, clinicians, and significant others of behaviors, feelings, and thoughts which indicate the onset of symptom destabilization, actions and activities which will avert the continued progress of symptom destabilization. A formal written acknowledgment of this plan is an Advance Directive.

RESPIRE CARE- A service designed to provide temporary residence for a person with a disability who ordinarily lives with family or friends or to assume temporary responsibility for care of the person in his or her own home. This service provides back-up support and in some cases relief to persons responsible for care of ill or disabled persons who ordinarily live in their household.

SAFETY NET- The responsibility of the public mental health system to serve people with mental health needs who would not otherwise receive services.

TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT OF 1999- Federal legislation that increases beneficiary choice in obtaining rehabilitation and vocational services; removes barriers that require people with disabilities to choose between health care coverage and work; and aims to provide Americans with disabilities a better opportunity to participate in the workforce.

TRANSITION- The time in which an individual is moving from one life/development stage to another. The change from childhood to adolescence, adolescence to adulthood, and adulthood to older adult.

UNBUNDLED SERVICES- When a residential provider takes services apart and instead of charging a flat per diem (per day fee), there is a charge for individual services, (i.e., room and board, counseling, partial hospitalization and diagnostic services).

WHITE HOUSE CONFERENCE- The first White House Conference on Mental Health calling for a national anti-stigma campaign in June of 1999.

Acknowledgements

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Surgeon General's Report

Howard Goldman, M.D., Ph.D., Senior Scientific Editor

Children and Adolescent Issues

Kim Kehl, Ohio Department of Mental Health
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Brenda Cronin, Ohio Department of Youth Services
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Anne Wolcott, Ohio Department of Job & Family Services

Fiscal/Financial Issues

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Adult Issues

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Florence Payne, North Central
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Cathy Stocksdales, Ohio Department of Aging

Cultural Competence

Somers L. Martin, Ohio Department of Mental Health

In addition to the individuals who provided testimony at the request of the Commission, this work could not have been completed without the assistance and leadership of the following people from ODMH who helped plan the forums, served as staff to the Commission and otherwise aided the development of this report.

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Mental Health and Schools

Wood County ADAMHS Board

Children and Adolescents

Beech Acres

Community Support Services

NAMI of Franklin County

Best Practices

Wright State University

Housing and Employment

ADAMHS Boards of Adams,
Lawrence and Scioto Counties and
The Coalition on Homelessness
and Housing in Ohio

Children and Families

Heartland Massillon

Criminal Justice

Paint Valley Mental Health, Alcohol
and Drug Addiction Board

Cultural Competence

Columbiana County Mental Health
and Recovery Services Board

Review and Next Steps

Council of Collaboratives

**A special thank you to staff at the ODMH Behavioral
Healthcare Organizations for the invaluable
assistance and support you provided at each forum.**

Commission Members

A. Leslie Abel

Les Abel is the Executive Director of the Stark County Community Mental Health Board, a position he has held since 1979. Previously, he had been the Assistant Director at the Stark Board and the Wayne-Holmes Board. Les had also directed the Child Assistance Program, a joint venture between the Erie/Ottawa Mental Health Board and the Vermillion Schools. He received his Bachelor's degree from the College of St. Charles Borromeo, did graduate work in Rome, Italy (where he played first base on an Italian baseball team). He received his Master's Degree in School Psychology from Kent State University. Les currently serves as the Chair of the Institutional Review Board at Mercy Medical Center and is on the Board of Directors of the Stark County Out of Poverty Partnership. He and his wife, Mary Ann, have three children.

Donald C. Anderson

Donald C. Anderson is the Deputy Director for Administrative Services at the Ohio Department of Mental Health. He supervises the information systems, fiscal administration and fiscal policy, support services, engineering and capital planning, human resources and labor relations, research and program evaluation functions of the Department. Mr. Anderson has served in a number of managerial positions over a twenty year career in state government, including four years as director of a major cabinet level department. He has been a management consultant providing organizational and project development consulting services to businesses and organizations.

Tracey J. Bennett, Ph.D.

Dr. Tracey J. Bennett is a Deputy Account Manager in the Cleveland District Office in the Ohio Department of Job and Family Services. She was previously employed in the Citizens of Cuyahoga County Ombudsman Office and had served as the Acting Director. She has also served as both the Vice-Chair and the Chair of the Cuyahoga County Community Mental Health Board while completing her terms of office as a Trustee. She received her Doctorate in Public Administration and Policy from Virginia Tech. Dr. Bennett has been actively involved with the Community Mental Health system for many years.

Leslie A. Bostic, Ph.D.

Dr. Leslie A. Bostic is the founding director and has been the Executive Director of The Buckeye Ranch for the past forty years. Dr. Bostic has served as a director on the State Savings Bank for 25 years. He has received a Community Services award from Governor Gilligan, was appointed to Commissions on Law Enforcement and Juvenile Justice by Governor Rhodes, and was honored with the Governor's Award to Ohioans by Governor Voinovich. Dr. Bostic is also the recipient of the: 1991 Socially Responsible Entrepreneur of the Year, 1995 Small Business Person of the Year Finalist (Central Ohio), 1997 The Columbus Foundation Award, and 1998 Public Service Award of The Ohio State University's Criminal Justice Research Center. He has also received the first Champion of Children award by the Columbus Montessori Education Center and the first annual Distinguished Service Award from the Grove City

Chamber of Commerce. Dr. Bostic holds a bachelor's and master's degree from the Richmond Professional Institute of the College of William and Mary and a Ph.D. from The Ohio State University. He is a Past-President of the Ohio Association of Child Caring Agencies (OACCA) and a past Officer of the American Association of Children's Residential Treatment Centers. He has dedicated his life to the development of state of the art treatment programs and services for emotionally and mentally disturbed children and families.

Susan D. Buchwalter, Ph.D.

Dr. Susan D. Buchwalter is the President and Chief Executive Officer of The Counseling Center of Wayne and Holmes Counties. She is also the Chief Executive Officer of The SourceOne Group, Inc., a private behavioral health company. Dr. Buchwalter is currently the Second Vice-president of the National Council for Community Behavioral Healthcare, and on the Board of the Mental Health Risk Retention Group (an insurance company specializing in behavioral health). She has served as the President of the Ohio Council of Behavioral Healthcare Providers, and is on the Board of Mental Health Care Corporations of America (MHCA). Dr. Buchwalter has a doctoral degree in Clinical Psychology from Kent State University. She is a member of the Ohio Psychological Association, the American Psychological Association, and the National Register of Health Service Providers in Psychology. She has over 30 years of experience in the Ohio mental health system.

Jeanne A. Clement, Ed.D., R.N., C.S., F.A.A.N.

Dr. Jeanne A. Clement is Associate Professor of Nursing and Psychiatry at The Ohio State University. She also collaborates with the College of Law faculty in providing mediation skills training for law and graduate psychiatric nursing students, and is a faculty member in the Summer Dispute Resolution Institute. Dr. Clement is co-founder and Board Chair of the Partners in Active Living Through Socialization, Inc. (a consumer operated peer support service), and is Chair of the Board of Trustees of North Central Mental Health Center (Columbus). She is on the Leadership Council for Leadership 2000+, and Associate Faculty at the Glenn Institute. She represents the Ohio Nurses' Association on the Coalition for Healthy Communities, and is an associate with the Collaborative for Conflict Management in Mental Health at the University of South Florida. Additionally, she is a member of the Primary Care Practice Guidelines task force for the International Society of Psychiatric Mental Health Nurses, sponsored by the Center for Mental Health Service of SAMHSA. Dr. Clement received her Doctorate in Nursing Education from Teachers College of Columbia University. Dr. Clement has over 20 years experience as a therapist in private practice and has consulted within the public mental health system in Ohio at the state, county and local levels.

Ed Comer

Ed Comer is the Director of Psychiatry Services at the School of Medicine, Wright State University. He is the retired Assistant Dean for Clinical Affairs and a member of

the Emeritus Psychiatry Faculty at the School of Medicine. He has received numerous community and academic awards for his efforts on behalf of the mentally ill and mentally retarded in Ohio.

Ed received his Masters Degree in Psychology from Xavier University in Cincinnati. Ed has been active throughout his 30 year professional career in leadership positions bringing institutions of higher education and public mental health systems together. He and his wife, Carol, have been foster parents to a developmentally disabled adult for the past 25 years.

Terrence B. Dalton, MEd., LSW

Terrence B. Dalton is the Director of Programs/Chief Operating Officer for Community Support Services, Inc. in Akron, Ohio. Previously he was the Executive Director for the Dodge County Mental Health/Developmental Disabilities/Alcohol & Other Drug Abuse Services Board in Juneau, Wisconsin. Terrence is currently the Chairperson for the Ohio Department of Mental Health's Community Support Planning Council. Terrence was the recipient of the Summit County Mental Health Association Outstanding Leadership Award in 1995. He is currently a surveyor for CARF — The Rehabilitation Accreditation Commission. Terrence received his Bachelor's degree in Psychology from the University of Wisconsin and his Master's degree in Counseling and Human Services from Boston University. Terrence and his wife, Sharon, have two children.

Cindy L. Holodnak

Cindy L. Holodnak is the Director of Management Development Programs for the John Glenn Institute for Public Service and Public Policy at The Ohio State University. Her office is responsible for the development and management of training and development programs for the public and nonprofit sector. She was previously the Director of the Graduate Programs Office for the Fisher College of Business at The Ohio State University, and the Assistant Director of the School of Public Policy and Management also at The Ohio State University. Cindy's work in the human service arena includes working with the Ohio Management Training Institute and the Michigan Employment and Training Institute as a trainer and as a Counselor Coordinator for the Allen County Employment and Training Office in Lima, Ohio. She has worked as an Outreach Social Worker at the Putnam County Mental Health Clinic, and as an Activities Leader for Northwest Community Mental Health Center in Lima. Cindy has a Bachelor of Arts Degree in Social Work from Ohio Northern University and a Master of Arts Degree in Public Administration from The Ohio State University.

Jerald Kay, M.D.

Commission Chair

Dr. Jerald Kay is Chair and Professor of Psychiatry in the School of Medicine at Wright State University, Dayton, Ohio. Dr. Kay is a Fellow of both the American College of Psychiatrists and the American Psychiatric Association. He is Chair of the Commission on the Practice of Psychotherapy by Psychiatrists and the Founding Editor of the

Commission Members

Journal of Psychotherapy Practice and Research published by the APA. Dr. Kay was designated as an Exemplary Psychiatrist by the National Alliance for the Mentally Ill in 1994, and, in 1995, was honored as Psychiatric Educator of the Year by the Association for Academic Psychiatry. He is the recipient of the 2001 APA Seymour Vestermark Award for his contributions to psychiatric education. Last year he was designated as the Outstanding Faculty of Wright State University. Dr. Kay completed his general and child and adolescent psychiatry residencies at the University of Cincinnati. He is a graduate and faculty member of the Cincinnati Psychoanalytic Institute. Dr. Kay has published extensively on the topics of medical and psychiatric education, medical ethics, child psychiatry, psychoanalysis, psychotherapy and the psychosocial aspects of AIDS and of cardiac transplantation.

Eric Ladd

Eric Ladd is the Executive Director/CEO of Partners in Franklin County (a consumer-operated peer support service). In 2000, Partners was awarded by Ohio Advocates for Mental Health "Consumer Operated Service of the Year. Eric has previously worked for the City of Cleveland Office of Consumer Affairs, American Greetings and Grumman Corporation. He is the prior chair of the Columbus Area Consumer Advisory Council to BVR; a Vice Chair to the Franklin County ADAMH Board Consumer Advisory Council and is currently a board member of Ohio Advocates for Mental Health. He is a representative to the Coalition to Healthy Communities and the Columbus

Mayor's Commission for People with Disabilities. Eric was a 1988 Finalist for the Columbus Dispatch Community Service Award, a 1999 recipient of the Franklin County Mental Health Association Consumer Advocacy Award (Norman Guitry) and in 2000 was awarded the Vocational Rehabilitation Southeast outstanding consumer placement award. He has a Bachelor of Business Administration from Ohio University and recently earned a certificate for the completion of the L2000+ Leadership Academy for Emerging leaders in Behavioral Healthcare from the John Glenn Institute for Public Service and Policy of the Ohio State University. Eric has participated in many other organizations in various capacities for which he has received numerous awards and accommodations.

Mark R. Munetz, M.D.

Mark R. Munetz, M.D., is a Professor of Psychiatry at the Northeastern Ohio Universities College of Medicine and the Chief Clinical Officer of the Summit County Alcohol, Drug Addiction and Mental Health Services Board. Dr. Munetz has held faculty positions at the University of Pittsburgh, University of Massachusetts and Case Western Reserve University. He received his undergraduate and medical school training at the University of Pennsylvania. Dr. Munetz completed an internship at the Lafayette Clinic in Detroit and completed his psychiatric residency at the Western Psychiatric Institute and Clinic of the University of Pittsburgh. He is a Fellow of the American Psychiatric Association and is currently the Treasurer of the Ohio Psychiatric Association.

Deborah Ann Nixon-Hughes, LISW

Debbie Nixon Hughes is the Chief of the Bureau of Mental Health for the Ohio Department of Rehabilitation and Corrections. She is responsible to plan, monitor, implement and evaluate a comprehensive mental health system for individuals incarcerated in the Ohio Prison system. Debbie has a budget of \$75M, and her Bureau also works with community providers to assure transition of mental health services for individuals released from prison to the community. She worked for 22 years in the community mental health system in a variety of positions including agency clinical and executive directorships and was the Deputy Director and the Acting Executive for the Hamilton County Mental Health Board before joining ODRC. She serves as a staff resource to the ODRC Parole and Community Services, and is a member of the National Association of Social Workers, and is on the ODMH Planning Council. Debbie received her Bachelor of Science degree from Morgan State University in Baltimore, Maryland, majoring in Community Mental Health Administration. She received her Masters Degree in Social Work with a focus on Administration at The Ohio State University. Debbie has been an adjunct professor at The Ohio State University for master level social work students and has taught graduate level mental health multi-disciplinary classes. She has presented workshops at several conferences on topics of diversity issues in treatment and in the work place, and on the provision of services to persons with severe mental illness.

Thomas M. Perrone, MSW, LISW

Thomas M. Perrone is the Executive Director of New Horizon Youth Center and North Point Consulting and Behavioral Health Services. He has spent his career providing individual, group and family therapy to children, adolescents and their families. He has developed inpatient, outpatient and residential treatment programs for institutions such as: Western Psychiatric Institute and Clinic, Southwood Psychiatric Hospital, Ohio Valley Medical Center, New Horizon Youth Center and North Point Consulting and Behavioral Health Services. He is a member of the National Association of Social Workers. Thomas received his Bachelors Degree in Psychology from Kent State University and his Masters Degree in Social Work from New York University.

Elise Mitchell Sanford

Elise Mitchell Sanford is a photographic artist with a 10 year exhibition record. She is the founder and Project Director of The Athens Photographic Project, teaching people with severe mental illness how to express and empower themselves through photography. Elise holds degrees in journalism from Tulane University, television from Iowa State University, and has both a Bachelor and Master of Fine Arts Degrees in photography from Ohio University. She is a member of the Board of Trustees of NAMI-Ohio.

Bernadette Schell

Bernadette Schell is Director of the NAMI Ohio Family to Family Education and Support program. Bernie is the daughter, mother, and grandmother of individuals with


Major Brain Disorders. She spends numerous hours of volunteer service to NAMI at the state and National level. She is/has been both a Member and the Secretary to the national NAMI Board, Founder and President of the Ohio NAMI Board, Founder and Leader of the Marion/Crawford County NAMI Board, Leader of the Montgomery NAMI Board. She has been both a Board Member and Secretary of the Montgomery County ADAMH Board. Bernie has served as a member of both the Common Concerns Committee and the Study Committee on Mental Health Services at the state level. Bernie has 64 years of experience with serious brain disorders and 22 years of experience with the public mental health system of care.

Karen Scherra

Karen Scherra is the Executive Director of the Clermont County Mental Health and Recovery Board. She is currently president-elect of the Ohio Association of Alcohol, Drug Addiction and Mental Health Services Boards. She was named as an Administrator of the Year 2000 by Ohio Advocates for Mental Health. Karen is a graduate of LaSalle and Hahnemann Universities with a Master's Degree in Mental Health Evaluation. Karen has been greatly influenced by her grandmother's commitment to, and subsequent death in, a Philadelphia State Hospital. She serves on a number of committees focused on the mental health system, including the Systems Linkage Committee and the System Financing Committee. She began her career working in an urban community mental health center. Karen is married with three children and she serves as a volunteer on boards and in various church activities.

Ella Thomas, ACSW, LISW

Ella Thomas is the Chief Executive Officer of the Cuyahoga County Community Mental Health Board. She has many years of Human Service experience, having worked at the Department of Human Services, with children and families as well as the elderly. She has community mental health experience and was the Chief Executive Officer of the Cleveland Psychiatric Institute (NBHS-Cleveland). Ella has served on various state policy committees including Inpatient Futures, Study Committee on Mental Health Services, Managed Care (MPH) and the House Bill 215 Planning Committee. She earned her Bachelor of Science Degree in Sociology/Health Education from North Carolina Central University and her master's Degree in Social Work from Case Western Reserve University. Ella and her husband, Douglas, have two sons. Outside interests include Church and community involvement. She has been a Girl Scout Leader for the past 5 years.



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